



KANSAS

DEPARTMENT OF HEALTH & ENVIRONMENT

BILL GRAVES, GOVERNOR

Gary R. Mitchell, Secretary

December 12, 1997

Dear Colleague:

I am pleased to transmit to you a copy of the **Kansas Maternal and Child Health Year 2000 Objectives: Midcourse Review & 1996 Revisions** which assesses 20 high priority Maternal and Child Health (MCH) objectives. More than 30 professionals representing services and programs to mothers, infants, children (including children with special needs), youth and families in Kansas contributed to this document. Overall responsibility for planning and preparing the content of this document was provided through the Kansas State Systems Development Initiative Project. In addition to the staff of the Bureau for Children, Youth and Families (BCYF), we appreciate the assistance from other staff in the Kansas Department of Health and Environment as well as the Kansas Department of Social and Rehabilitation Services.

Because of the interest and support that many of you have provided to BCYF as a Health Advisory Coalition for Children, Youth and Families (HACCYF) member or through other affiliations, we welcome any review and comments you may wish to provide to us. We particularly would like to learn if the publication is easy to understand, if it serves as your primary source of information on Kansas maternal and child health, and in what ways you will use the information presented in this document. You may submit your comments, questions and requests for additional information to Jan Bueker (913/296-6467) or Linda Kenney, the State Systems Development Initiative Project staff. In addition to the **Kansas Maternal and Child Health Year 2000 Objectives: Midcourse Review & 1996 Revisions** publication, we have included a promotional Kansas Maternal and Child Health Year 2000 Objectives magnet and a complimentary **Title V Maternal and Children Health Services Block Grant** brochure.

Sincerely,

Gary R. Mitchell, Secretary
Kansas Department of Health and Environment

Enclosures

KANSAS

**MATERNAL AND CHILD HEALTH
YEAR 2000 OBJECTIVES**

MIDCOURSE REVIEW & 1996 REVISIONS



Logo from the Maternal & Child Health Bureau, Health Resources & Services Administration

**BUREAU FOR CHILDREN, YOUTH AND FAMILIES
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
OCTOBER, 1997**

The principal authors and other contributors of this document express sincere appreciation to Patricia Schloesser, MD, Topeka, Kansas for sharing her time and expertise in the review of the final draft. Her ongoing commitment to the women, children, youth and families of Kansas is praiseworthy. Dr. Schloesser is a national maternal and child health consultant and was the recipient of the American Public Health Association's Martha May Eliot award in 1992. This year she was accorded an honorary membership in the Association of Maternal and Child Health Programs (AMCHIP) in recognition of her contributions to the improvement of maternal and child health.

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INTRODUCTION

Background

Beginning in 1990, Healthy People 2000 has provided the Kansas Department of Health and Environment, the Kansas Maternal and Child Health (MCH) agency, a framework for identifying and prioritizing MCH objectives pertaining to health status, risk reduction and services and protection.

Kansas Maternal and Child Health Year 2000: Midcourse Review & 1996 Revisions (1997) is the fourth MCH-specific report to review the progress toward the year 2000 objectives. The first and second documents (printed in 1990 and 1993 respectively) reviewed a total set of fifty-eight objectives, of which eighteen were explicitly developed by the Kansas Bureau of Family Health¹ and forty were derived from the Healthy People 2000. Forty-one of the total set were identified as high priority, thirteen as medium priority and four as low priority objectives. In 1995, an independent consultant group, the University of Kansas Medical Center Project Team, prepared a five-year state MCH needs assessment which examined 30 MCH objectives. All of the objectives in the 1995 needs assessment were identified by the Maternal and Child Health Bureau (MCHB) as relevant to maternal and child health although some of them were not derived from or consistent with Healthy People 2000.

This 1997 Kansas Midcourse Review document reassesses 20 objectives, all selected by the MCHB as high priority MCH objectives. Nineteen of the twenty are included in or are related to the Healthy People 2000 document. The inclusion of the one exception, Children in Poverty, is explained in greater detail in Appendix A. The nineteen objectives are identified with thirteen Healthy People 2000 priority areas: Maternal and Child Health, Nutrition, Tobacco, Alcohol and Other Drugs, Family Planning, Violent and Abusive Behavior, Unintentional Injuries, Environmental Health, Oral Health, Chronic Disabling Conditions, HIV Infection, Sexually Transmitted Diseases and Immunizations. Beginning with this 1997 Review, the current status of progress toward the objectives includes all additions and modifications since the 1995 document.

Midcourse Modifications

The midcourse review was the result of ongoing data updates and graphic modifications beginning in the fall of 1995 as well as several short-term workgroup sessions meeting in the fall/winter of 1996. BCYF workgroups met to consider new data and new information since the release of the 1993 document. As a result of the review process, many objectives while important were dropped in order to focus on the twenty remaining objectives. Four of the MCH objectives combine more than one Healthy People 2000 objective (i.e., Unintentional Injuries, Suicide, Substance Use [Alcohol, Cigarettes, Smokeless Tobacco and Marijuana] and Sexually Transmitted Diseases). One Kansas-selected objective, Breastfeeding, is listed

1. The Bureau of Family Health was reorganized in 1995 into the current Bureau for Children, Youth and Families.

under two Healthy People 2000 Priority Areas, Nutrition and Maternal and Child Health. Two of the MCH objectives are Healthy People 2000 subobjectives (i.e., HIV Infection - Women and Homicide - Black Male Youth). Finally, BCYF reviewed subobjectives under Infant Mortality according to race/ethnicity population groups and according to the postneonatal and neonatal rates as well. Most of the baselines are the same as those established in the original 1990 and 1993 documents, others reflect revisions to the original baseline or are newly created.

Summary of Progress

Movement either toward or away from the Year 2000 target is determined by the direction of change between the baseline and the most recent data point. For some objectives, variations are relatively small and may be recorded as no change. In circumstances pertaining to objectives with more than one measure (“compound” objectives), if the data show movement in different directions, progress is labeled as “mixed.” In some cases, the objective is tracked either with subobjectives in addition to or instead of the priority objective. Finally, a few objectives are very broad in scope and tracking data are not available.

The following summary of progress is based on all 20 objectives, including those which have been revised since the 1995 needs assessment. At the midpoint of the decade, 35% of the objectives have either been reached or are showing **substantial progress** in meeting the goal: Prenatal Care, Newborn Screening (both screening results and follow-up results), Infant Mortality (including the NIMR and PIMR subobjectives), Breastfeeding (both in early postpartum period and the 5-6 month period), EPSDT participation, Immunizations, and Sexually Transmitted Diseases (both Gonorrhea and Chlamydia). Data for 25% of the objectives indicate regress or **movement in the wrong direction** rather than progress toward the Year 2000 target: Child Abuse and Neglect, Black Male Homicide, Suicide, Substance Use (Alcohol, Cigarettes, Smokeless Tobacco and Marijuana), and Children in Poverty. An overall **mixed direction** is indicated in 5% of the objectives: Child Injury Deaths (including Motor Vehicle Accidents, Drowning, and Fire-related). **No substantial change** has occurred in 10% of the objectives: Low Birthweight (including Very Low Birthweight) and Adolescent Pregnancy. **Baselines have yet to be established** or comparable data obtained above two years from the baseline year for 25% of the objectives: HIV Infection, Hearing Impairment, Blood Lead Levels (both ≤ 10 $\mu\text{g/dL}$ and ≤ 15 $\mu\text{g/dL}$), Dental Sealants, and Systems Development. Table 2, Appendix B, shows the progress of the Kansas priority MCH objectives.

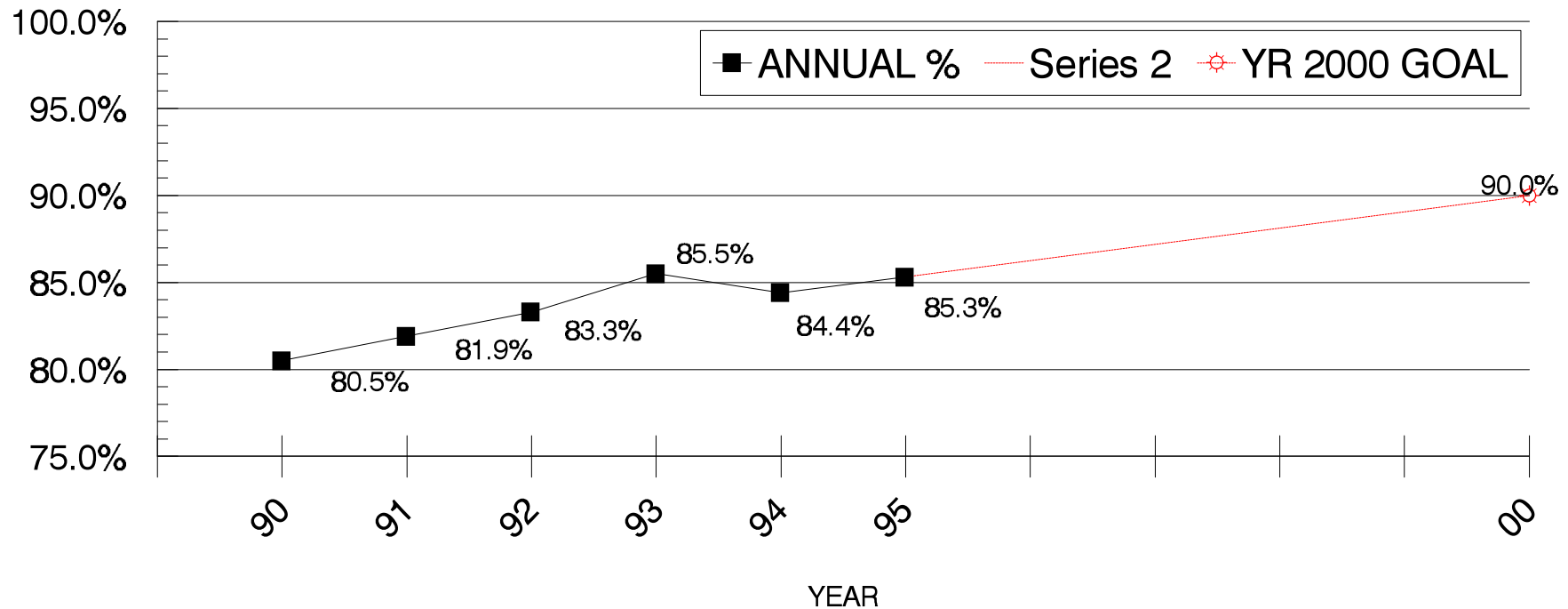
PRENATAL CARE

KANSAS OBJECTIVE	Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. (Kansas Prenatal Care Index)
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Significance Prenatal care is defined as pregnancy-related health care services provided to a woman between conception and delivery. The prenatal care that women receive is the second most important determinant of birth outcome, after socioeconomic status. Pregnant women who receive inadequate prenatal care are at increased risk of bearing infants who are low birth weight, are stillborn, or die within the first year of life. An expectant mother with no prenatal care is three times as likely to have a low birth weight baby. Despite the importance of early prenatal care in protecting against low birth weight and infant mortality, nearly one in seven pregnant women in Kansas did not enter care during the first trimester of pregnancy in 1995. Early, high-quality prenatal care is especially crucial for women at increased medical and/or social risk. Maternal characteristics associated with receiving late or no prenatal care include low income, less than a high school education, adolescent pregnancy, and a large number of children.

PERCENT OF WOMEN RECEIVING PRENATAL CARE in the first trimester of pregnancy

Kansas Goal for the Year 2000 = 90% pregnant women receiving 1st trimester PNC



Data Source: Kansas Vital Statistics, Natality data
National MCH Goal = 90%

Baseline Data In 1989, 80.3 % of women delivering live born infants, entered care during the first trimester; 82.2% White; 65.6% Black; 67.2% Other Non-White. The Prenatal Care Index reflected 84.8% of women delivering live born infants (where all data necessary for the analysis was available) received adequate prenatal care. [Note: 614 certificates out of 38,034 were lacking data for analysis]

Data Source Kansas Vital Statistics - Natality data, Kansas Department of Health and Environment

Progress/Trends Since 1990, there has been **substantial progress** in the number of Kansas women delivering liveborn infants who entered prenatal care during the first trimester, with an overall increase of 6%. The Other Non-White races made the most notable increase (13.7%), followed by Black (11.2%) and White (5.4%). There was a 2.3% increase in Kansas women delivering liveborn infants who received adequate prenatal care between 1990 and 1995. Again, the Other Non-White races made the most notable increase (9.7%), followed by Black (4%) and White (2%) in the percent of women receiving adequate prenatal care. Since 1992, when the first complete Pregnancy Nutrition Surveillance Program data report became available, there has been a 16.6% increase in the percent of WIC clients, who delivered liveborn infants and entered care during the first trimester. The WIC data is by client self report.

In Kansas, there continues to be a disparity between the White and Black races pertaining to early entry into and compliance with the recommended number of prenatal visits. A prenatal access study completed by the Kansas Regional Perinatal Program's Medical Council in the late 1980's indicated that women with medical cards had difficulties with access to medical prenatal care services due to lack of providers accepting Medicaid clients. In addition, women of the Black race reported more personal, cultural, transportation and system barriers to accessing prenatal care. Substantial racial and ethnic differences in the proportion of mothers receiving care has also been observed nationally.

With the expansion of Medicaid managed care in the 1990's, it is anticipated that access to prenatal care will be improved, although managed care in itself does not resolve the cultural and personal barriers, nor does it assist the client in acknowledging the pregnancy and/or making the effort to apply for financial assistance to access care.

HIV INFECTION - WOMEN

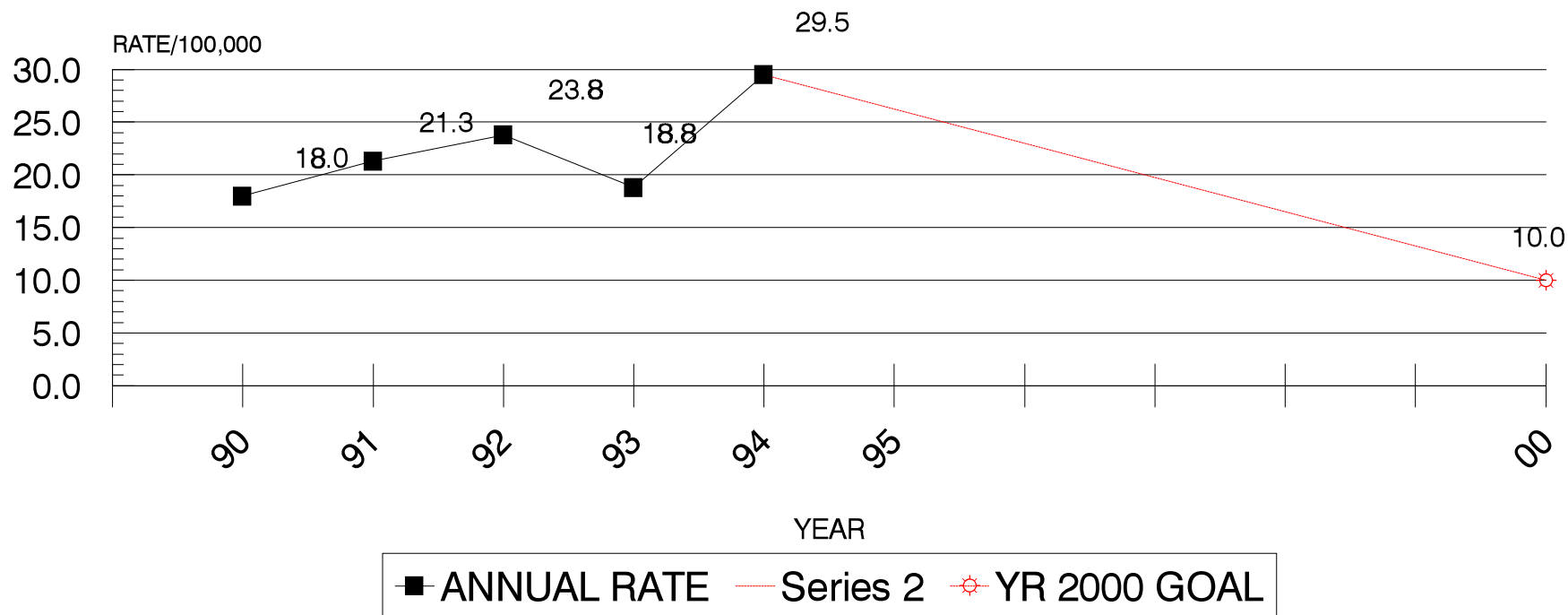
KANSAS OBJECTIVE	Confine the prevalence of HIV infection among women giving birth to live-born infants to no more than 10 per 100,000. ¹
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Significance The human immunodeficiency virus (HIV) epidemic is a multifaceted state, national and international problem. Without treatment, within 10 years of infection with HIV, about 50 percent of people will acquire acquired immunodeficiency syndrome (AIDS) and another 40 percent or more develop other clinical illnesses associated with HIV Infection.

Newborn infants are routinely screened for treatable metabolic disorders by blood samples collected shortly after birth. These samples can also be tested for the prevalence of an HIV antibody that has been transferred from the mother, indicating that the mother is infected with HIV. It should be emphasized that HIV infection among women giving birth, not among their infants, is measured by this technique. Kansas currently screens newborn blood samples of HIV antibody only if ordered by private physicians and through private clinics and/or hospitals. The transmission rate of HIV from mother to infant is estimated to be between 20% and 40%.

PREVALENCE RATE OF HIV INFECTION among Women giving birth to live-born infants

Kansas Goal = 10 per 100,000 Women giving birth to live-born infants



Data Source: AIDS Program, Bureau of Disease Prevention and Health Promotion, KDHE

National MCH Goal = 100 per 100,000 Women giving birth to live-born infants

1990 data partial year only beginning in May

Baseline Data 1990 data indicated a rate of 18 women testing positive for every 100,000 women giving birth to live-born infants. A KDHE, Bureau of Disease Control study entitled, *Seroprevalence Study in Childbearing Women in Kansas: May 1990-April 1994* tested all 151,323 newborn babies for HIV antibodies. The total number of HIV positive tests was 37 for a four year rate of 24 per 100,000 women giving birth to live-born infants.

Data Source AIDS Program, Bureau of Disease Prevention and Health Promotion, KDHE

Progress/Trends Data on HIV infection among child-bearing women has **not been collected long enough** to validate likely trends. However, the increasing rate of heterosexual transmissions of HIV is likely to increase the rate of infection in this population in the future.

Family planning clinics in Kansas continue to screen high risk women for HIV. Currently, KDHE procedures are screening of pregnant women who are high risk so that those testing positive can receive treatment to minimize infection in the infant. KDHE receives limited federal funding for services including zidovudine (AZT), a specific antiviral drug, for pregnant HIV infected women whose physician prescribes medication for prophylaxis in preventing perinatal transmission. AZT for infants is also covered if the family meets eligibility criteria. Currently Medicaid does not reimburse for HIV testing of pregnant women, however Medicaid will cover prenatal, perinatal care, medications and care for the infant after delivery for HIV infected women.

According to the *Seroprevalence Study in Childbearing Women in Kansas: May 1990-April 1994*, 20 of the 37 HIV positive antibody tests were to White Women (61% of HIV positives) and 13 were to Black Women (39% of HIV positives). Women in the 20 to 29 years age range accounted for 27 of the 37 HIV positives (79%). Women in two age ranges (i.e., 15-19 years of age and 30-39 years) accounted for 3 of the 37 apiece (tied at 9%). Both the Northeast Kansas and Southcentral Kansas districts had 12 HIV positives (33%). Counties in the Northeast district include five counties with a county population above 50,000: Douglas, Johnson, Leavenworth, Shawnee and Wyandotte. Counties in the Southcentral district include three counties with a county population above 50,000: Butler, Reno and Sedgwick.

In the Fall of 1995, CDC asked that all states receiving funds to conduct the HIV Seroprevalence Study of Childbearing Women (SCBW) suspend testing of samples collected for the study. The suspension came at a time when Congress was debating the ethics of using federal funds to support double-blinded testing as prescribed in the SCBW protocol.

1. The National Goal is to confine the prevalence of HIV Infection among women giving birth to live-born infants to no more than 100 per 100,000.

LOW BIRTHWEIGHT AND VERY LOW BIRTHWEIGHT

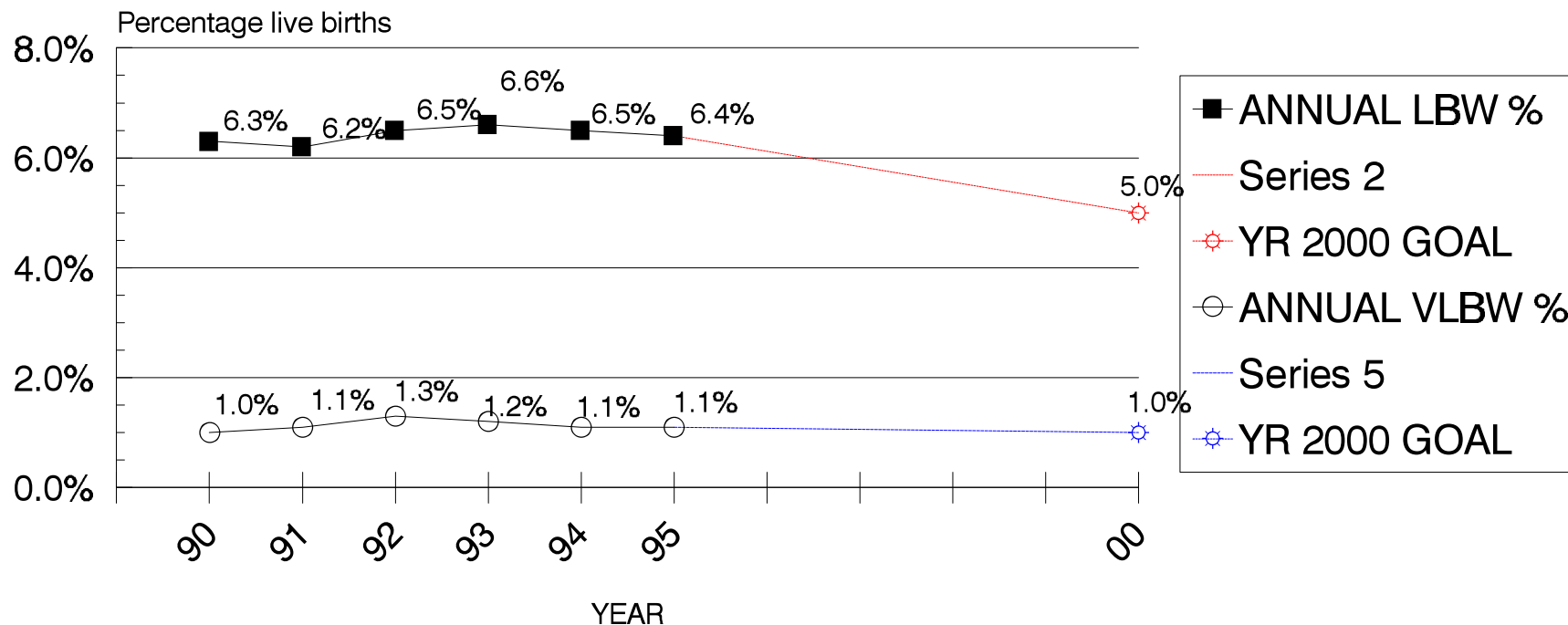
KANSAS OBJECTIVE	Reduce low birthweight to an incidence of no more than 5 percent of live births and very low birthweight to no more than 1 percent of live births.
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Significance Low birth weight (LBW) infants are live birth infants weighing less than 2500 grams (5.5 lb.) at birth. Very low birth weight (VLBW) infants weigh less than 1500 grams at birth. They fall into two categories: those who are small because they are born prematurely (fewer than 37 weeks of gestation completed) and those who are full-term babies, but are small for their gestational age (intrauterine growth retardation). Very low birth weight births are primarily associated with preterm birth. A number of risk factors for low birth weight have been identified, including younger and older maternal age, high parity, poor reproductive history (especially history of low birth weight), low socioeconomic status, low level of education, late entry into prenatal care, low pregnancy weight gain and/or low prepregnancy weight, smoking, and substance abuse. These infants account for nearly two-thirds of all deaths under 28 days of age (neonatal mortality) and 60% of all infant deaths in the first year of life.

LBW infants who survive past their first year are still at increased risk of mental retardation, birth defects, growth and developmental problems, visual and hearing defects, delayed speech, autism, cerebral palsy, epilepsy, learning difficulties, chronic lung problems, and abuse and neglect. Adolescents are much more likely to give birth to LBW infants than mothers in their 20s, and the risks are greatest among the youngest adolescents. Children born into poverty are at increased risk of being low birth weight.

INCIDENCE OF LOW BIRTH WEIGHT AND VERY LOW BIRTH WEIGHT

Kansas Goal for the Year 2000: 5.0% LBW of live births; 1.0% VLBW



Data Source: Kansas Vital Statistics, Natality Data

National MCH Goal = 5.0% LBW; 1.0% VLBW

Baseline Data In 1989, 6.1 percent of all live births were low birth weight (< 2500 grams). For Black live births, the percentage was 12.9. For White live births, LBW was 5.5%. The same year, 1.1 percent of all live births were very low birth weight (< 1500 grams). Of the 434 VLBW live births, 78.1% were White infants and 19.6% were Black infants.

Data Source Kansas Vital Statistics - Natality Data, Kansas Department of Health and Environment

Progress/Trends There has been **little noticeable change** in low birth weight data during the past 16 years for all three groups (White, Black and others non-White) in Kansas.

Over a four-year period (1989-1992), Sedgwick County had the highest number of total low birth weight births (2,116), followed by Wyandotte (889) and Johnson (717) counties. In those counties averaging over 250 births per year, the highest percentages of LBW births were in Wyandotte (7.8%), Seward (7.3%), Sedgwick (7.1%) and Shawnee (7.0%). Eight counties in southeastern Kansas along the Oklahoma border had LBW percentages above the upper quartile (6.6%) for the state. These counties are: Chautauqua (11.7%), Cherokee (11.4%), Elk (8.2%), Montgomery (7.8%), Cowley (7.2%), Greenwood (6.9%), Wilson (6.9%) and Labette (6.75%).

NEWBORN SCREENING

KANSAS OBJECTIVE	Screen all newborns ¹ for phenylketonuria (PKU), congenital hypothyroidism (CH), galactosemia (GAL), and hemoglobinopathies (HGB). Track number of newborns screened annually. All newborns who have been screened presumptive positive for PKU, CH, GAL or sickle cell disease will receive appropriate treatment. ²
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Significance Conditions identified through newborn screening procedures are ones which are otherwise difficult to detect. Most infants with disorders identified through screening appear perfectly healthy at birth. There are body disorders that when undetected may be life threatening, lead to slowed physical development, mental retardation or other health problems. Of the four genetic disorders in which newborns in Kansas are screened, two disorders, PKU and congenital hypothyroidism, tend to receive virtually universal screening in all 50 U.S. states.

Congenital Hypothyroidism, a condition resulting from an inadequate production of thyroid hormones, may be due to a number of causes including endemic cretinism, agenesis or ectopic thyroid gland, and genetic disorders of thyroid hormonogenesis, etc. Patients who are not identified and treated promptly suffer mental retardation and variable degrees of growth failure, deafness, and neurologic abnormalities as well as classical hypometabolic symptoms of hypothyroidism. With screening, diagnosis and treatment, there is no physical disability.

Phenylketonuria (PKU), an autosomal recessive aminoacidopathy, leads to mental retardation when untreated. Without screening, physical disabilities include convulsions, hyperactivity, and eczema common. With screening, diagnosis and treatment, there is no physical disability. Most cases are a result of phenylalanine deficiency but some are due to bipterin cofactor deficiencies.

Sickle cell diseases and other hemoglobinopathies are autosomal recessive disorders resulting from synthesis of abnormal β -chains of hemoglobin. Sickle cell is common in Blacks, with less severe forms common in Arabs, East Indians, and those of Middle Eastern, Southern European, Caribbean, South American, and Central American descent. Significant mortality and morbidity are associated with sickle cell because of increased susceptibility to severe bacterial infections. Meningitis, pneumonia, and septicemia are major diseases of death among children with the disorder. Without screening, aseptic necrosis of bones, leg ulcers, neoproliferative retinopathy, serious infections, cerebral thromboses, renal concentrating defects, and delayed maturation could develop. Early diagnosis and immediate entry into programs of comprehensive care, including the initiation of penicillin prophylaxis, has been found to reduce the morbidity and mortality associated with sickle cell.

Galactosemia, a congenital metabolic disorder caused by the inherited absence of an enzyme that catalyzes galactose, leads to an increased risk of death from overwhelming infection in early infancy, with failure to thrive, vomiting, liver disease, cataracts and mental retardation in untreated survivors. It is lethal in most cases. A galactose-free diet should be begun as soon as possible and continued throughout life. Treatment should be initiated within the first week of life to avoid early death.

KANSAS NEWBORN SCREENING RESULTS (NUMBER OF INFANTS WITH CONFIRMED DIAGNOSIS /* PRESUMPTIVE POSITIVE or **ELEVATED TEST RESULTS)			
Disease	1993	1994	1995
	37,283 live births	37,269 live births	37,087 live births
PKU (5mg% or >)	1 / 41*	3 / 70*	4 / 70*
CH (TSH 20µIU/mL or >)	11 / 2253**	10 / 929**	15 / 987**
GAL (no galactose-1-phosphate uridyl transferase activity)	0 / 16*	3 / 7*	1 / 5*
SICKLE CELL DISEASE (phenotype FS)	2 / 12*	2 / 4*	11 / 13*
FOLLOW-UP RESULTS (PERCENT OF INFANTS FOLLOWED)	97%	74%	86%

Baseline Data Data were unavailable prior to 1993. Kansas requires newborns¹ to be screened for PKU, galactosemia, hypothyroidism, and hemoglobinopathies. Required hemoglobinopathy testing began on July 1, 1993. No data are available concerning numbers of parental refusal for screening.

Data Source KDHE Vital Statistics & Laboratory - Natality & Neonatal screening data

Progress/Trends Newborn screening is mandated, collection is required prior to hospital discharge, program criteria for a valid screen have been established and abnormal screens are retested in Kansas. Kansas has a protocol for tracking infants and intrastate follow-up is provided. Since 1993, this objective has **moved in the right direction**. The process for matching birth certificate data with newborn screening information to identify a percentage of infants screened was implemented in February 1997. Electronic data entry and transfer of matched data does not have a target implementation date however. In the new system, once fully functional, there will be an interaction of information from hearing risk assessment, newborn screening and birth certificate data.

1. All newborns except those newborns whose parents refuse the testing as a violation of a religious tenet or practice.
2. The National Goal is to increase to at least 95 percent the proportion of newborns screened by State-sponsored programs for genetic disorders and other disabling conditions and to 90 percent the proportion of newborns testing positive for disease who receive appropriate treatment.

INFANT MORTALITY RATE

KANSAS OBJECTIVE	Reduce the infant mortality rate to no more than 7 per 1,000 live births.
	Reduce the infant mortality rate among Blacks to no more than 11 per 1,000 live births.
	Reduce the infant mortality rate among other non-Whites to no more than 9 per 1,000 live births. ¹
	Reduce the neonatal mortality rate to no more than 4.5 per 1,000 live births.
	Reduce the neonatal mortality rate among Blacks to no more than 7 per 1,000 live births.
	Reduce the postneonatal mortality rate to no more than 2.5 per 1,000 live births.
	Reduce the postneonatal mortality rate among Blacks to no more than 4 per 1,000 live births.
	Reduce the postneonatal mortality rate among other non-Whites to no more than 3 per 1,000 live births. ²

Significance

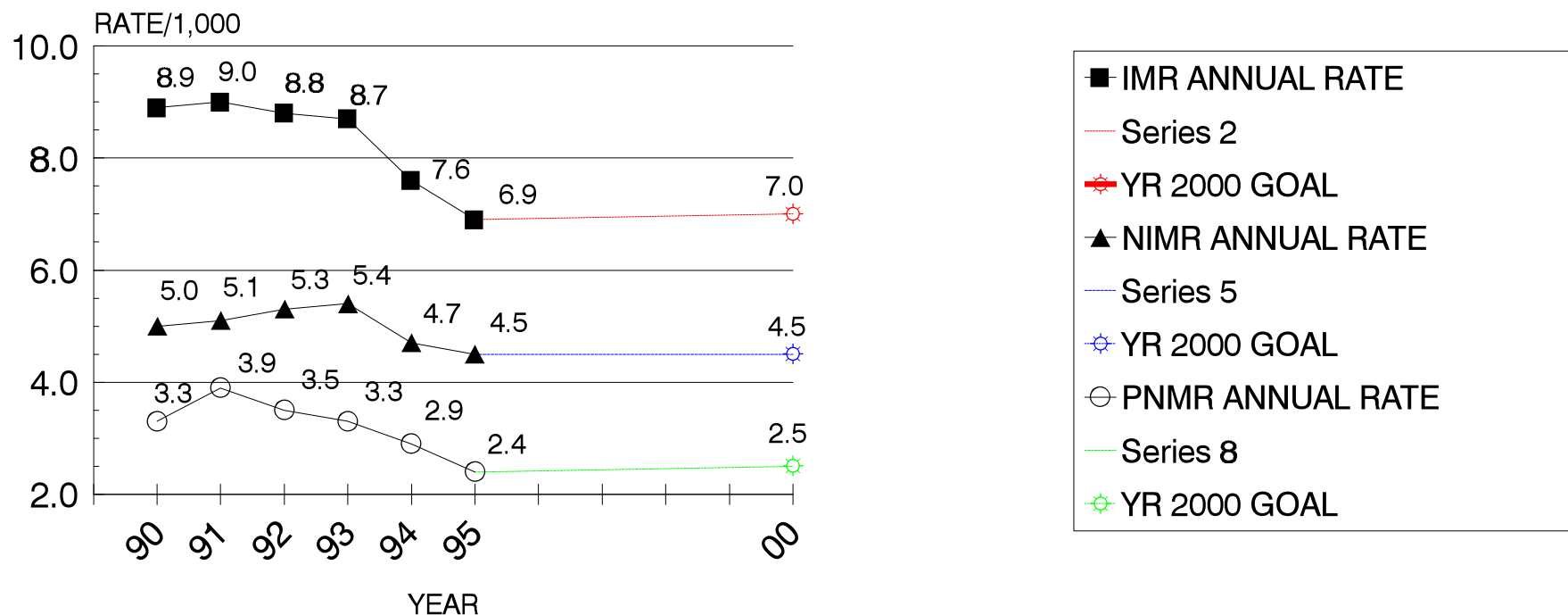
The infant mortality rate (IMR) is generally regarded as a quality of life indicator of both the health and welfare of a population. The infant mortality rate is defined as the number of infants who die between birth and one year of age per 1,000 live births. Disparities among population groups may reflect differences in access to adequate food, shelter, education, sanitation and health care. Neonatal mortality tends to be closely associated with low birth weight and with influences occurring prenatally, during birth, and in the newborn period - such as poor maternal nutrition, and health habits, lack of high-quality obstetric and neonatal health services, and congenital defects not compatible with life. Post neonatal mortality generally tends to be associated with environmental circumstances for the infant, particularly those linked to poverty - such as inadequate food or sanitation, unsafe housing, lack of health care services, and inadequate supervision.

The risk factors for the infant most commonly measured and found to be associated with infant mortality are: low birth weight, congenital defects, inadequate intrapartum and neonatal care, high birth order, and race. Risk factors for the mother include: women under age 18 or over age 35, previous fetal or infant loss, poor health prior to or during the pregnancy, inadequate or delayed prenatal nutrition, low socioeconomic status, low educational attainment, smoking and substance use. Differences in IMR by race/ethnicity may be due to such factors as income, access to medical care and the prevalence of risk factors noted above. The five leading causes of death are the same for both Black and White infants. Although the rank order differs by race, the five leading causes of infant death in Kansas are: congenital anomalies, sudden infant death syndrome (SIDS), immaturity, maternal conditions and respiratory conditions. The leading cause of death for Black infants is disorders related to short gestation and unspecified low birth weight. The leading cause of death for White infants is congenital anomalies.

INFANT MORTALITY RATE

NEONATAL AND POSTNEONATAL MORTALITY RATE

Kansas Goal: 7/1000 live births (IMR); 4.5/1000* (NIMR), 2.5/1000* (PNMR)



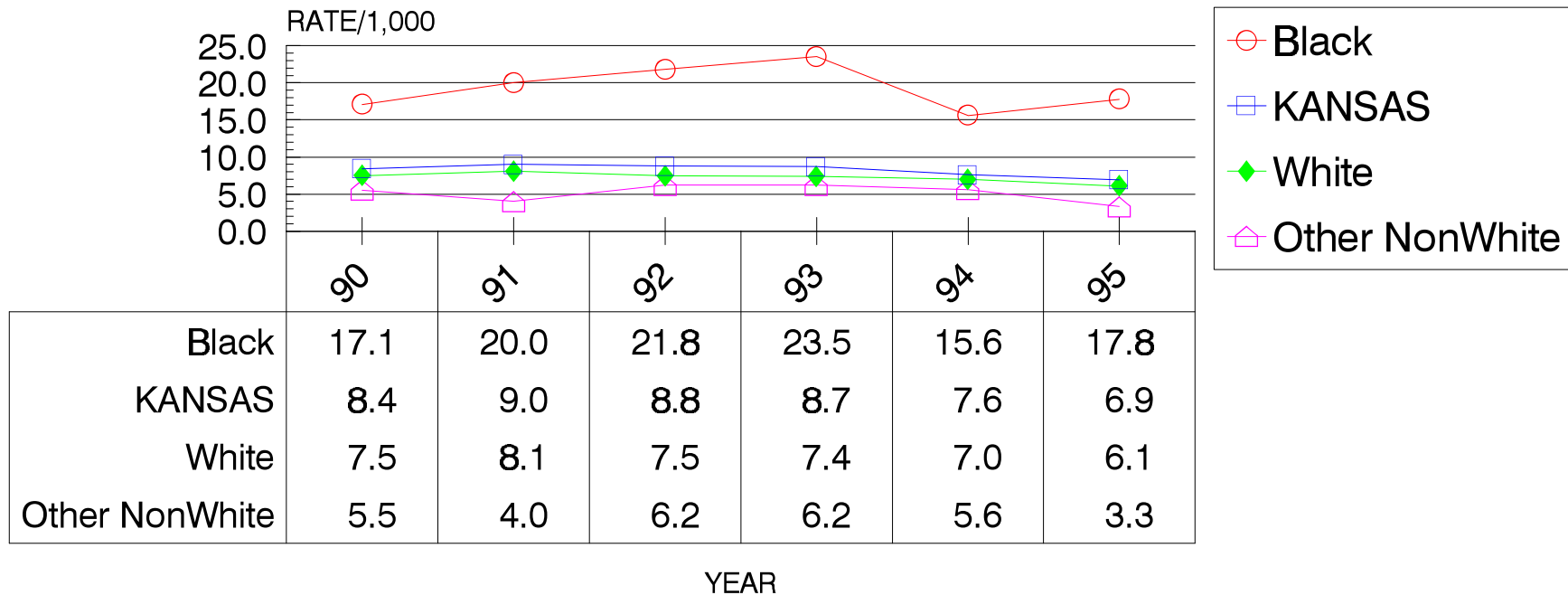
Data Source: Office of Vital Statistics, KDHE Note: * All rates per 1000 live births

National MCH Goal for the Year 2000 = 7.0/1000* IMR; 4.5/1000* NIMR; 2.5/1000* PNMR

NIMR = infant deaths under 28 days; PNMR = infant deaths 28 days through the 11th month

INFANT MORTALITY RATE by Race

Kansas Goal: 7/1000 live births (All); 11/1000 live births (Black)



Data Source: Office of Vital Statistics, Kansas Department of Health and Environment

National MCH Goal for the Year 2000 = 7.0/1000 live births (All); 11/1000 live biirths (Black)

Baseline Data There were 8.9 infants deaths (infants under 1 year) per 1,000 live births in 1990 for all racial and ethnic groups. In 1990, the IMR was 7.5 for Whites, 17.1 for Blacks, and 5.5 for people of other racial groups.

Data Source Kansas Vital Statistics - Mortality and Natality Data, Kansas Department of Health and Environment

Progress/Trends The total IMR has **continued to improve substantially** since 1991, yielding a 23% decline. The decrease in postneonatal mortality appears to have more impact on the decline in infants deaths, than the decrease in the number of neonatal deaths. There has been an 11.7% decrease in the neonatal rate and a 38.5% decrease in the postneonatal mortality rate from 1991.

Most apparent of the infant mortality trend is the continued disparity between the White infant mortality rate and the IMR for Black infants. There has continued to be an approximate three fold incidence in the number and rate of Black infant deaths compared to the White infant deaths.

In 1995 of all infant deaths, 16.4% were attributed to SIDS, 41.0% to conditions originating in the perinatal period, 24.2% attributed to congenital anomalies, and 18.4 % to all other causes. Immaturity was the major cause under conditions originating in the perinatal period.

1. The national goal is to reduce the infant mortality rate among American Indians and Alaskan Natives to no more than 8.5 per 1,000 live births and the IMR among Puerto Ricans to no more 8.0 per 1,000 live births.
2. The national goal is to reduce the infant postneonatal mortality rate among American Indians to no more than 4 per 1,000 live births and the PIMR among Puerto Ricans to no more that 2.8 per 1,000 live births.

Is there anything more precious -
and more vulnerable -
than a newborn?
Or more deserving of a family's love
and a society's care?

- RICHARD M. SMITH
Editor-in-Chief and President
Newsweek, 1997

BREASTFEEDING

KANSAS OBJECTIVE	Increase to at least 75% the proportion of women who exclusively or partially breastfeed their babies in the early postpartum period and to at least 50% the proportion who continue breastfeeding until their babies are 5 to 6 months old.
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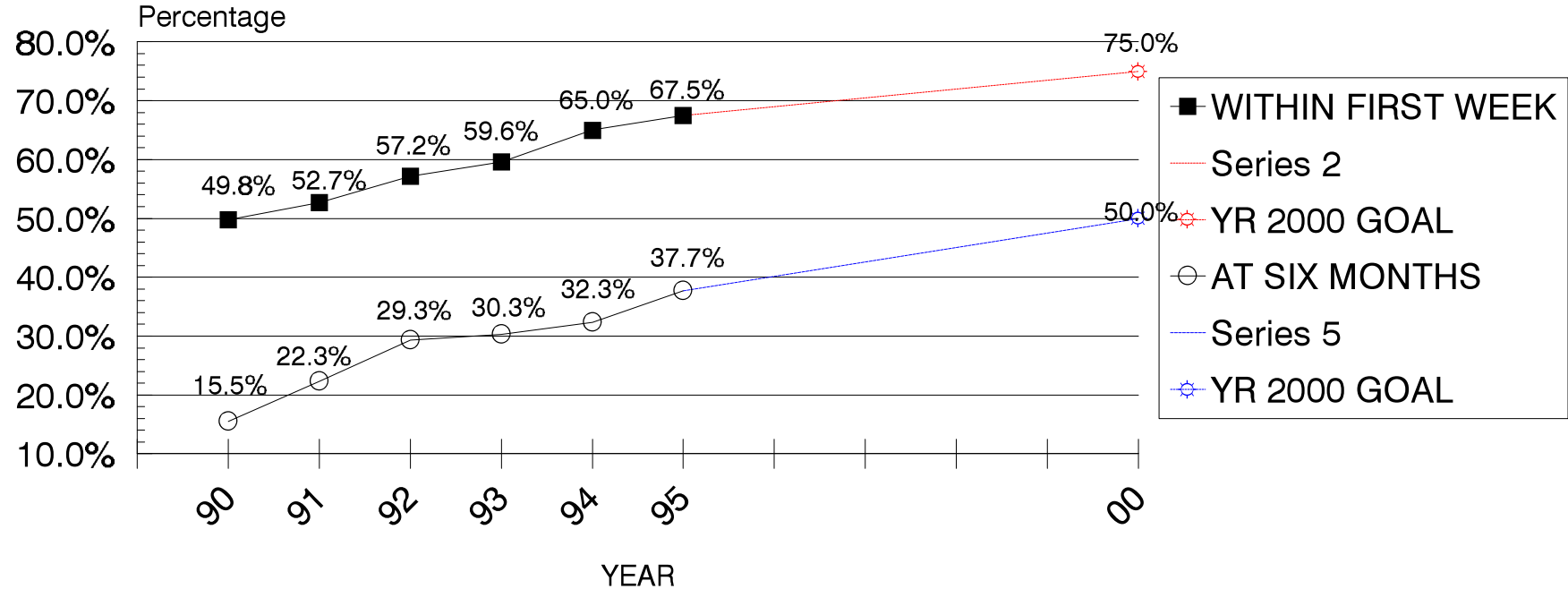
Significance Breastfeeding is the optimal way of nurturing full-term infants while simultaneously benefiting the lactating mother. Breastmilk is the right temperature and easier for the infant to digest. Breastfeeding provides the infant all the nutrients, enzymes and immunoglobulin needed in the first four months of life. The ideal balance of anti-infective and anti-inflammatory substances, hormones, and growth factors is provided by the mother's milk. Breastmilk changes to match the changing developmental needs of the infant. Most breastfed infants have less upset stomach, colic and diarrhea. Breastmilk may also prevent infant allergies and infections. Furthermore, studies suggest that breastfed infants have fewer serious diseases and disorders (e.g., diabetes, malocclusions).

Breastfeeding provides a time of intense mother-infant interaction. Lactation also facilitates the physiologic return to the prepregnant state for the mother. For instance, breastfeeding can help the mother return to her normal weight because the energy is used from stored fat to produce the milk. A national survey of breastfeeding women indicated that breastfeeding rates continue to be highest among older, well-educated and relatively affluent women. Women in the lower rate group tended to be low-income, Black and less than age 20. Women who are HIV positive, use certain drugs, and take more than minimal amounts of alcohol should avoid breastfeeding.

PERCENT OF BREASTFEEDING MOTHERS

Initiation and Continuation

Kansas Year 2000 Goal = 75%* in early postpartum period; 50% who continue**



Data Source: PedNSS-WIC, Centers for Disease Control and Prevention (CDC)

National MCH Goal = 75% early postpartum period; 50% continue until babies are 5-6 months old

* = exclusively or partially breastfeed; ** = until babies are 5 to 6 months old

Baseline Data In 1990, 49.8% of mothers enrolled in the WIC Program breastfed their infants at hospital discharge; 15.5% of these mothers were still breastfeeding at six months postpartum.

Data Source Pediatric Nutrition Surveillance System, CDC

Progress/Trends From 1990 through 1995, the initiation and continuation of breastfeeding rates among WIC participating mothers, have demonstrated a **remarkable progress** toward reaching the Year 2000 Goal. The existing trend indicates that the rate for mothers who initiate breastfeeding in early postpartum is likely to equal or surpass the Year 2000 Goal of 75%. Moreover, the trend indicates a high feasibility that the rate for mothers who continue breastfeeding at six months will reach or surpass the Year 2000 Goal of 50%.

Since 1989 WIC has been taking an active role through local agencies to increase breastfeeding rates. In 1991, a Health and Human Services Breastfeeding grant (four years) was received by the Kansas University Medical Center in Kansas City. Key components of this grant were training of health professionals and development of community task forces to foster appropriate breastfeeding promotion and management practices within the communities. Kansas is among many states that lack data on the impact of maternal employment and breastfeeding rates.

In 1996, Kansas WIC received a grant to develop a breastfeeding Peer Counselor Program. A breastfeeding Peer Counselor is a mother who has breastfed one or more infants, successfully completed a training program and is competent to provide breastfeeding advice and information. Information regarding breastfeeding is included in the M & I Perinatal Manual.

HEARING IMPAIRMENT

KANSAS OBJECTIVE	Assure hearing screening for 90% of infants and toddlers birth through age 2 ¹ by State-sponsored early identification programs. ²
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Significance The future of a child born with a significant hearing impairment depends to a very large degree on early identification (i.e., audiological diagnosis of infants and toddlers birth through age 2) followed by immediate and appropriate intervention. If hearing impaired children are not identified early, it is difficult, if not impossible, for many of them to acquire the fundamental language, social, and cognitive skills that provide the foundation for later schooling and success in society. When early identification and intervention occur, hearing impaired children make remarkable progress, are more successful in school and become more productive members of society. The earlier intervention and habilitation begin, the more apparent the benefits.

KANSAS HEARING SCREENING DATA - 1995		
HOSPITAL COMPLIANCE		
Birthing hospitals in Kansas	N = 101	
Hospitals in compliance with the Newborn Risk Screening for Hearing Impairment Program	N= 89	88%
Hospitals not in compliance	N = 12	12%
EARLY IDENTIFICATION SCREENING		
Live births in Kansas	N = 37,087	
Live births that received Newborn Risk Screening for Hearing Impairment	N = 30,108	81%

Data Source: Newborn Infant Hearing-Impairment Risk Questionnaire [KSA 1990 Supp. 651.150]

Of those screened, 26,912 were not at risk for hearing impairment (89%), 3,196 were at risk for hearing impairment (11%), and 59 children were reported to KDHE with hearing impairment. It is not mandatory to report follow-up hearing evaluation results. Kansas law mandates that newborns receive hearing risk screening. Hearing screening as a follow-up to those newborns identified to be at risk is encouraged but not mandated by law.

Baseline Data Baseline data is not available. However, based on 37,574 live births in Kansas (1988), it is estimated that 10 percent or 3,757 infants, were at risk for hearing impairment at birth and of that number, 2.5 percent, or 94 infants, will have a sensorineural hearing loss.

Data Source Newborn Infant Hearing-Impairment Risk questionnaire [distributed to all Kansas medical care facilities that are required to provide infant risk screenings under KSA 1990 Supp. 65-1.150].

Progress/Trends Although **baseline data has yet to be established** for this objective, there is a growing awareness in Kansas of the need for newborn risk screening for hearing loss. This coincides with the growing trend nationally to require newborn hearing screening before the newborn leaves the hospital.

With the increase of community-based collaboration in Child Find programs there is an increase in the number of birth through two-year-olds who access the programs available statewide (e.g., EPSDT, Count Your Kid In) and are able to participate in hearing screening. Part H eligible infants/toddlers must have their hearing screened as a component of the Individualized Family Service Plan (IFSP). In 1995, Child Find Programs screened 8,847 infants and toddlers (ages 0- 2).

1. The National Goal is to reduce the average age at which children with significant hearing impairment are identified to no more than 12 months.
2. The State-sponsored early identification program in Kansas is Infant-Toddler Services which is provided through Part H of Public Law 99-457 and administered through the Kansas Department of Health and Environment.

EPSDT PARTICIPATION

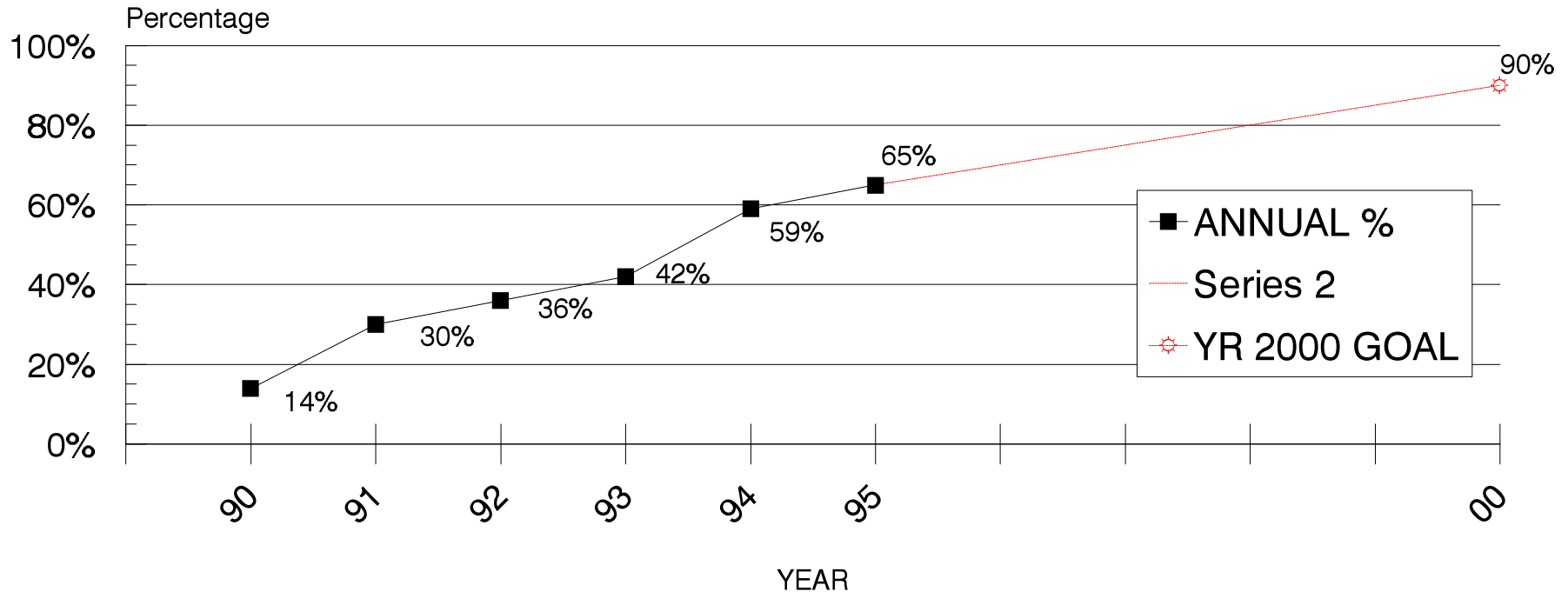
KANSAS OBJECTIVE	Increase to at least 95% the proportion of EPSDT eligible children who participate in the full complement of EPSDT services, including physical health, mental health, oral health, vision and hearing, all periodic screening as recommended by the American Academy of Pediatrics, any indicated interperiodic screening, and all needed diagnosis and treatment.
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Significance

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, is intended to ensure that all Medicaid-eligible children under 21 receive comprehensive, periodic assessments of their physical and mental health and follow-up services to diagnose and treat any problems discovered as part of the screening process. The emphasis is on preventive and primary care, with the central goal of preventing childhood illness or disability through immunizations and health education, and identifying and treating conditions early on, before they become serious and disabling. To be effective, screening needs to: begin at an early age; be available to all children regardless of socioeconomic condition; and be conducted on a regular basis. The mission of the Kansas EPSDT program (KAN Be Healthy, also well-child care) is to assure access and receipt of primary and preventive health care for all children. Early detection and treatment of physical, mental health, oral, visual and hearing deficits and restrictions, can help children: (1) improve their cognitive, social and communication skills and (2) avoid or reduce later academic problems.

PROPORTION OF EPSDT ELIGIBLES who participate in full compliment of EPSDT services

Kansas Goal for the Year 2000 = 90% of EPSDT eligibles



Data Source: Kansas Dept. of Social and Rehabilitation Services, Medicaid

National MCH Goal = 95% of EPSDT eligibles

EPSDT services include physical, mental & oral health; vision, hearing & periodic screening

Baseline Data In 1990 the EPSDT participation rate was 14 percent of eligible children.

Data Source Electronic Data Systems [until November 1, 1996], Blue Cross Blue Shield of Kansas¹

Progress/Trends **Considerable progress** has been realized each consecutive year since 1990. SRS' preliminary 1996 report to HCFA is based on the number of KAN Be Healthy claims filed and indicates a 70% statewide participation rate. It does not include the Medicaid HMO statistics.

Managed care is legislatively mandated to be implemented by July 1, 1997. Medicaid managed care and welfare circumstances are beginning to impact KAN Be Healthy. Managed care has created a greater demand from the private sector for certified nurses. Currently, there are 435 child health assessment nurse providers (CHANP) nurses certified to provide preventive child health services, screening and appropriate referral on the local level. In June 1991, there were 273 certified nurses.

The impact on local health departments (LHD) is not yet known. However, SRS continues to encourage private providers to approve a blanket referral for KAN Be Healthy screens in LHD. There is ongoing collaboration among agency representatives of health, education, and social and rehabilitation services continues to: provide a quality child health care delivery system in Kansas, improve provider availability through education, inform and educate clients, and coordinate and enhance funding.

1. Electronic Data Systems (previously) and Blue Cross Blue Shield of Kansas (currently) function as the fiscal agent for the Kansas Department of Social and Rehabilitation Services and assume the responsibility of the data source for the state agency.

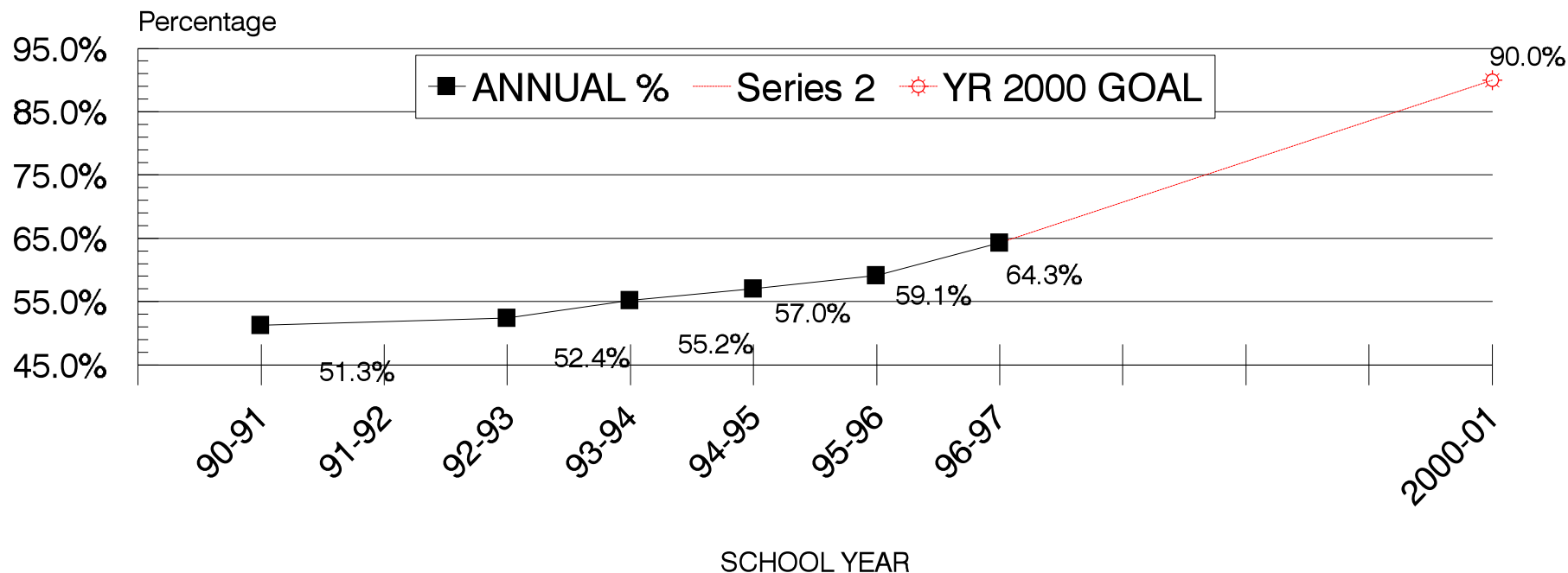
IMMUNIZATIONS

KANSAS OBJECTIVE	Increase to at least 90 percent the proportion of children ≤ 24 months who complete the basic 4:3:1 immunization series (diphtheria, tetanus, pertussis; oral polio; measles, mumps, rubella inoculation). ¹
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Significance Immunization status is a measurable indicator of nonsusceptibility to specific infectious diseases. Immunity to disease is the ability of an individual to resist infection and may be conferred through artificial immunization or through previous natural infection. Immunization status is not a health outcome; however, it is closely and indisputably linked to rates of childhood diseases and is a good short-term predictor of long-term changes in disease incidence. Hence, immunization rates for a population are a valid surrogate measure of health outcomes or disease rates. Immunization rates for two-year-old children serve as a proxy measure for the proportion of young children receiving well-child health care. High immunization rates for school-aged children reflect compliance with state laws requiring evidence of immunization at the time of first enrollment in school. Because the infectious agents of vaccine- or toxoid-preventable childhood diseases have not been eradicated, any decline in immunization rates can be expected to increase the risk of new outbreaks of these diseases, with an increase in unnecessary disability and death as a result.

PROPORTION OF CHILDREN IMMUNIZED having completed the basic immunization series*

Kansas Goal for the Year 2000 = 90% children 24 months in age or less



Data Source: Immunization Program, BDPHP, KDHE National MCH Goal = 90%

Survey: Kansas Certificate of Immunization (2 Yr Retrospective, Population-based)

*Series (4:3:1) = diphtheria, tetanus, pertussis; oral polio; measles, mumps, rubella inoculation

Baseline Data No cases of diphtheria, tetanus, measles, polio and congenital rubella; 2 cases of rubella; 6 cases of pertussis; and 205 cases of mumps were reported in 1988. Kansas tracks the proportion of children immunized through three data sources. Data from the first data source show that 51.3 % of children 24 months in age or less were adequately immunized in the 1990-91 school year. In 1995, 82.5% of a random group of children 19-35 months of age were adequately immunized according to the second data source. Finally, 82.45% of children in the Kansas WIC Program 0-24 months in age were immunized as were 83.81% of children in the Kansas WIC Program 12-60 months in age.

Data Sources Kansas Certificate of Immunization (2 year retrospective study), Bureau of Disease Prevention and Health Promotion; National Immunization Survey (NIS), Centers for Disease Control and Prevention; and, Kansas WIC Program.

STATE IMMUNIZATION RATES: KANSAS WIC PROGRAM; September 1996			
* Age in Mos.	Category 1 & 4	All	Percent
0-24	21,578	26,171	82.45%
12-60	36,439	43,473	83.81%
TOTAL =		69,644	

*Category 1= Complete Category 4= Appropriate after shots today

Progress/Trends In 1995, there were 0 cases of diphtheria, congenital rubella, mumps and polio; 1 case of measles; 23 cases of pertussis; 1 case of rubella; and 2 cases of tetanus in Kansas. According to the Kansas BDPHP, because of the widespread use of childhood vaccinations, no cases of polio or diphtheria have been reported in Kansas in the past ten years. The number of tetanus (one in 1994) and rubella (zero in 1994) cases have also been greatly reduced. For a variety of reasons (e.g., suboptimal vaccine coverage of pre-school children, lower vaccine efficacy for some vaccines, asymptomatic transmission), measles, pertussis (whooping cough), and mumps have not been eliminated; however case numbers have decreased substantially since the late 1980s for all but pertussis. The **progress for this objective has been favorable**. *Kansas Medicine*, 95 reports that data from the 1993-1994 retrospective study of kindergarten students indicate that Kansans has not achieved the 90% goal for any single vaccine, although it is reasonably close for measles-mumps-rubella (81% coverage for two-year-olds) and diphtheria-tetanus-pertussis vaccine (86% for two-year-olds). The recent addition of Hepatitis B vaccination to the basic childhood series is expected to eventually result in notable decreases in new cases of Hepatitis B.

According to the February 23, 1996 *Morbidity and Mortality Weekly Report* (Centers for Disease Control and Prevention, National, State and Urban Area Vaccination Coverage Among Children 19-35 Months - United States, Vol. 45, No.7), Kansas was one of 26 states in the 75%-84% range for estimated vaccination with the 4:3:1 series. Only three states ranked in the $\geq 85\%$ range. For the 4:3:1:3 series² estimated vaccination coverage, Kansas was one of 22 states in the 75%-84% range with only one state (Vermont) in the $\geq 85\%$ range.

Operation Immunize administered 12,882 doses to 6,177 children in April 1996. 3,188 or 51% of the children were under the age of two. Immunization records of children under age 2 participating in the WIC Program are current for 82% of the population served. By state regulation, Kansas requires that children in all day care centers to be current on their immunizations.

1. The National Goal is to increase basic immunization series among children under age 2: at least 90 percent.
2. 4:3:1:3 is four doses of diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids (DTP/DT), three doses of poliovirus vaccine, one dose of measles-mumps-rubella (MMR), and three doses of Hemophilus influenza type b vaccine (Hib).

There is no magic period of the life of a child. Each and every period is a magical and important one . . . Our task, therefore, is not to find the right age to intervene, but the right intervention at each age.

- EDWARD F. ZIGLER,
Handbook of Early Childhood Intervention

BLOOD LEAD LEVELS

KANSAS OBJECTIVE	Reduce the prevalence of elevated levels of blood lead $\geq 15 \mu\text{g/dL}$ to less than 81 cases per 100,000 children aged 6 months to 5 years and the prevalence of elevated levels of blood lead $\geq 10 \mu\text{g/dL}$ to less than 232 cases per 100,000 children aged 6 months to 72 months. ¹
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Significance An elevated blood lead level is defined as a level in the blood high enough to require medical evaluation for the possibility of adverse mental, behavioral, physical, or biochemical effects. Lead plays no useful function in body chemistry. At very high doses, many organs and systems are affected by lead, including the kidney, liver, gastrointestinal tract, myocardium, immune system, blood, reproductive system (in both males and females), and central and peripheral nervous systems. As a result, children with high blood levels may experience severe anemia, sensorimotor deficits, mental retardation, blindness, convulsions, coma, and death. There is growing evidence that even at slightly elevated levels, lead exposure can produce verbal, perceptual, motor, and behavioral disabilities in children, including hearing impairment, irritability, delayed physical and neurobehavioral development, inattentiveness, inability to follow instructions, and lowered test scores for reading, spelling and IQ. Exposure of the fetus to lead, even at relatively low levels, as measured from umbilical cord blood, has been associated with minor anomalies, neurobehavioral disabilities, shortened gestation, low birth weight, and growth deficits after birth. The number of children within a defined population found to have elevated blood lead levels reflects the extent of the community's effort to regularly screen and treat high-risk populations and to reduce environmental sources of lead (e.g., lead-based paint found in old, deteriorating housing; lead plumbing in old buildings and lead soldering in new or renovated buildings, urban house dust).

KANSAS PEDIATRIC BLOOD LEAD LEVELS²				
YEAR	$\geq 10 \mu\text{g/dL}$ # cases*	$\geq 10 \mu\text{g/dL}$ Rate per 100,000	$\geq 15 \mu\text{g/dL}$ # Cases	$\geq 15 \mu\text{g/dL}$ Rate per 100,000
1994	1034	388.0	362	135.8
1995	1281	480.7	494	185.4

Data Source: Office of Epidemiologic Services, KDHE

* includes 15 $\mu\text{g/dL}$ cases

Baseline Data Baseline data collection started in 1994. This baseline data is very limited and is representative of only a very small population of Kansas residents. The 1994 data is based only on blood lead screens performed by the state lab with services limited to clients of local health departments, and St. Francis Hospital in Wichita which is the only laboratory serving private practitioners.

Data Source Office of Epidemiologic Services, Kansas Department of Health and Environment

Progress/Trends CDC continues to lower the standard for the level of blood lead that requires referral for further observation and treatment. Prior to 1985 the standard was $\geq 30 \mu\text{g/dL}$ per tenth

of a litre of blood. After 1985, the standard was $\geq 25 \mu\text{g/dL}$, then $\geq 15 \mu\text{g/dL}$ was added in 1990. In 1995-1996, a blood lead level $\geq 10 \mu\text{g/dL}$ joined the other two levels to be identified as a health threat. Kansas has **two years of comparable data** for this objective on the number of cases and rates of pediatric blood levels $\geq 15 \mu\text{g/dL}$ and $\geq 10 \mu\text{g/dL}$ among children aged 6 months to 5 years.

In October of 1991, CDC issued new guidelines for blood lead screening and recommended universal screening of all children ages 0-6. In 1993, Medicaid made annual blood lead level testing mandatory for the Kan-Be-Healthy program. Through the Kan-Be-Healthy program, a verbal risk assessment is performed. If risk is determined, then a blood lead screening is also completed.

In 1995, Kansas had twenty-one counties with at least 11 cases of pediatric lead poisoning. The geographic distribution is as follows: Northeast Kansas = 7 counties (Franklin, Jackson, Leavenworth, Nemaha, Pottawatomie, Shawnee, Wyandotte); Southeast Kansas (Anderson, Bourbon, Butler, Cherokee, Coffey, Cowley, Crawford, Lyon, Montgomery, Woodson) = 10 counties; Southcentral Kansas = 3 counties (Reno, Sedgwick, Sumner); and, Southwest Kansas = 1 county (Ford). Northwest and Northcentral Kansas had ten or less cases of pediatric lead poisoning.

In 1995, a KDHE intra-bureau working group reviewed current state capacity, developed and published "Childhood Lead Poisoning Prevention Guidelines." The group obtained CDC funding in 1997 to support formation of the KDHE Childhood Lead Poisoning Prevention Program within the Bureau of Environmental Health Services. The program's mission is to establish a network of trained personnel to identify, screen and recommend proper medical and environmental management of lead-poisoned children. Four key areas of the childhood lead poisoning problem are addressed: training, education, screening and data collection.

1. The National Goal is to reduce the prevalence of blood lead levels exceeding $15 \mu\text{g/dL}$ and $25 \mu\text{g/dL}$ among children aged 6 months-5 years to no more than 300,000 and zero [cases], respectively.
2. While pediatric blood lead poisoning was first reported in 1993, only state analysis was conducted and data is incomplete. 545 cases of lead levels $\geq 10 \mu\text{g/dL}$ were reported that year.

DENTAL SEALANTS

KANSAS OBJECTIVE	Obtain baseline data or a scientifically-based estimate on the proportion of children who have received protective sealants on the occlusal surfaces of permanent molar teeth. ¹
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Significance Children ages 6 through 8 are at an important stage of dental development; they have a complement of primary teeth as well as their permanent first molars and incisors. The importance of optimal oral health for these children cannot be overemphasized; it is critical not only for their current oral functioning, but also for long-term health. Dental caries, a unique microbial infection, remain among the most prevalent and preventable diseases of adults and children. Once established, it is progressive, does not heal without treatment, and leaves visible evidence of past infection. Because early diagnosis and prompt treatment of caries can halt tooth destruction and prevent tooth loss, low prevalence of untreated caries should be attainable. The exact incidence and prevalence of dental caries in Kansas is not currently known. National studies have shown that the application of dental sealants reduce by two-thirds the incidence of dental caries. Protection against caries is 100% in pits and fissures that remain completely sealed.

Dental sealants, also referred to as protective sealants and/or pit-and-fissure sealants, are thin plastic coatings that are applied to the chewing surfaces of molars and premolars. Sealants are most effective when they are applied to teeth just after eruption of the first and second molars - when children are approximately aged 6 through 8 (for first molars) and when they are aged 12 to 14 (for second molars). When applied properly, the sealants are exceptionally safe, highly effective, long lasting and substantially decrease the chances that children and adolescents will develop dental caries.

For children from low-income families, a significant obstacle is paying for services. Even when the child is Medicaid eligible, very few dental providers will accept the child as a client due to low Medicaid reimbursement rates. In addition to financial constraints, cultural, psychological, social and geographic barriers can contribute to lack of dental treatment for children.



Baseline Data	Baseline data is needed to determine current status and track future progress.
Data Source	Not applicable.

Progress/Trends The state health agency in recognition of the significance of oral health in Kansas, hired a state dental director in July 1995. The director and the state dental association have

prioritized this objective and are planning to enlist local dentist involvement in obtaining statewide data in order to **establish a baseline** and track future progress.

1. The National Goal is increase to at least 50 percent the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth. NOTE: Progress toward this objective will be monitored based on prevalence of sealants in children at ages 8 and 14, when the majority at first and second molars, respectively, are erupted.

CHILD ABUSE AND NEGLECT

KANSAS OBJECTIVE	Reduce to less than 4 per 1,000 children the incidence of confirmed maltreatment of children younger than age 18 (includes physical abuse, sexual abuse, emotional abuse, or neglect). ¹
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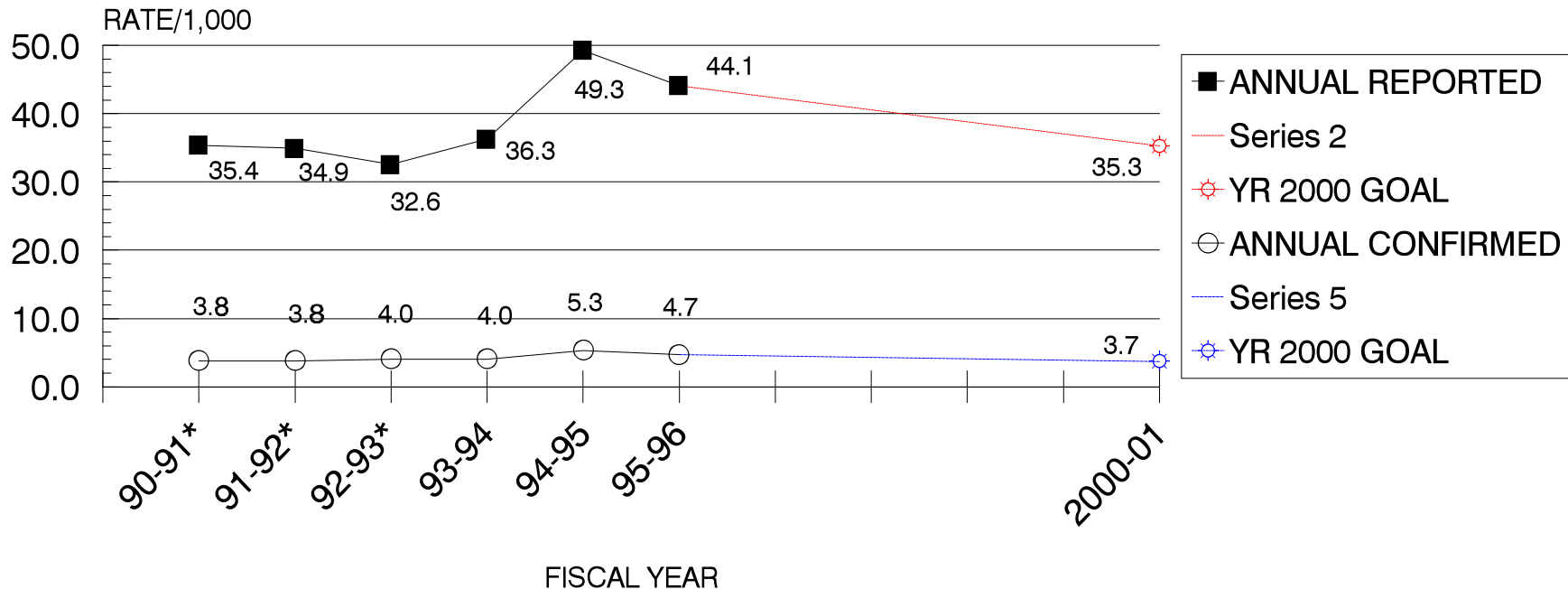
Significance Child abuse is a general term encompassing any physical injury, psychological or emotional abuse, sexual abuse or exploitation and neglect inflicted upon a child. All of these terms describe the failure of a caretaker or a community to protect and provide responsible care and nurturance for a child. Physical injury constitutes any physical abuse of a child by non-accidental means, and is often at variance with the explanation given for the injury. Sexual abuse is any sexual act, such as indecent exposure, improper touching to penetration (sexual intercourse) that is carried out with a child. Emotional abuse is a consistent, chronic behavior by a parent or a caretaker that has a harmful effect on a child and is detrimental to the child's development of a sound and healthy personality. Physical neglect of a child means the failure or inattention on the part of the caregiver or parent to provide that child's basic needs, such as food, clothing, shelter, medical care, and supervision.

Child abuse carries high costs, both for individuals and society. Seriously abused and neglected children are at high risk for developmental delays, school-related problems, and permanent neurological and physical impairment. They typically experience severe emotional problems and lasting psychological damage throughout their lives. Sexually transmitted diseases are frequent sequelae of child sexual abuse, and unwanted pregnancies are not uncommon. Abusive parents are more frequently marked by their own childhood maltreatment, low self-esteem, very young parenthood, single parenthood, and inadequate knowledge of or preparation for caretaking. Stress resulting from unemployment, overcrowded living conditions, and isolation from social support also can be risk factors.

RATE OF CHILD ABUSE & NEGLECT

Cases Reported and Reports Confirmed

Kansas Goal for the Year 2000 = Rate/1,000 < 35.3 cases reported; < 3.7 reports confirmed



Data Source: SRS, Commission of Children & Family Services * = Data prior to 93-94 is unreliable

National MCH Goal = < 25.2 per 1,000 (Pop.-based) ALL RATES PERTAIN TO CHILDREN YOUNGER THAN AGE 18

Maltreatment includes physical abuse, sexual abuse, emotional abuse, or neglect

Baseline Data Data prior to 1993 is unreliable due to systems issues that have since been corrected. We advise caution in interpreting Child Abuse and Neglect data until the reliability of the data is well-established. With that qualification, baseline data is as follows: in 1990-91, the rate for reported cases of child abuse and neglect was 35.4 per 1,000, the confirmed rate was 3.8.

Data Source Commission of Children & Family Services, SRS

Progress/Trends SRS data from 1993-96 indicates that there has been an increase in the rate of cases of child abuse and neglect reported as well as an increase in rate of reports confirmed. Unfortunately, this objective is indicating **movement in the wrong direction** of the Year 2000. According to SRS data, sexual abuse was the most confirmed type of maltreatment with 4,362 (or 32.2%) confirmed cases, followed by physical abuse (3,549 cases or 26.2%), physical neglect (3,073 or 22.7%), child in need of supervision (1,852 or 13.7%), emotional abuse (389 or 2.9%) and medical neglect (301 or 2.2%). When interpreting this data, it is important to realize that a child could represent one or more specific cases of abuse. Therefore, the actual number of children victimized is uncertain.

Understandably, substantial numbers of abused and neglected children are never identified or, if identified, never reported. A large number of discrete agencies and institutions play a significant role in identifying and resolving cases of child abuse and neglect. Health institutions (e.g., LHDs, clinics, emergency rooms), schools and day care facilities, the police and courts, and child protection agencies are the most obvious examples. In Kansas, services that help to enhance parenting skills of young and at-risk parents and/or help improve children's social skills, problem-solving abilities, self-esteem and long-term school performance, are a promising intervention (e.g., Parents as Teachers, Head Start, Healthy Start Home Visiting).

1. The National Goal is to reverse to less than 22.6 per 1,000 children the rising incidence of maltreatment of children younger than age 18 (4.9/1000 incidence of physical abuse; 2.1/1000 incidence of sexual abuse; 3.0/1000 incidence of emotional abuse; and, 14.6/1000 incidence of neglect). Data source for the national data is the National Incidence of Child Abuse and Neglect Survey, Office of Human Development, National Center on Child Abuse and Neglect (NCCAN). **According to NCCAN, Kansas' reported and confirmed child abuse case data, like all other states' data, is not comparable to the national data.**

CHILD & YOUTH INJURY DEATHS (UNINTENTIONAL & INTENTIONAL)

KANSAS OBJECTIVE	Reduce by 15% unintentional (including motor vehicle crashes, motorcyclists, bicyclists, and pedestrians; drowning deaths; and residential fire deaths) and intentional ¹ (homicide and suicide) deaths among children, adolescents and young adults ages 0 to 24. Track number annually. ²
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Significance An unintended injury death is a fatal accident or injury that results from an unanticipated and nondeliberate event. Motor vehicle accidents, drowning, and fires are among the leading causes of accidental death among children and youths. Vulnerable infants cannot perceive dangers in their environment, and even if they do primitively perceive dangers, they cannot move out of harm's way. Toddlers are beginning to learn to walk, using short, unsteady steps; hence their predisposition to physical injury. Their natural curiosity, without knowledge or experience to counter their impulses, can result in the exploration of dangerous areas. School-age children are carefree and careless; both qualities are essential for a happy and explorative childhood but are contrary to life and limb in a hazardous environment. Adolescents are risk takers; that is a part of the transitional period from childhood to adulthood. Certain risk taking ventures make for more mature adults; other risks can end an adolescent up in the emergency room or morgue. Children and adolescents who survive potentially fatal accidents may suffer severe permanent physical or mental damage requiring extensive treatment or extended care. Possible consequences to survivors include brain damage, broken bones, spinal cord injuries, injury to internal organs, extensive scarring, loss of limbs or loss of the use of limbs, and loss of vision and hearing. The medical, financial and emotional consequences of accidental fatalities and near-fatalities can be devastating.

For intentional injuries, see also the Black Male Homicide and Suicide objectives.

INJURY DEATHS AMONG KANSAS CHILDREN AND ADOLESCENTS AGES 0 TO 24 YEARS							
Cause of Injury	Year / Number of Injury Deaths						
	1990	1991	1992	1993	1994	1995	YR 2000 GOAL
Motor Vehicle Accidents	179	143	152	133	169	135	152.2
Drowning/Submersion	16	16	19	19	12	9	13.6
Fire	10	17	17	7	12	8	8.5
Homicide	38	55	54	77	80	74	32.3
Suicide	49	61	65	67	50	71	41.7

Data Source: Kansas Vital Statistics, Mortality Data

Baseline Data In 1990, 179 children, adolescents and young adults ages 0 to 24 died as a result of motor vehicle accidents. Also, in 1990, drowning/submersion fatalities were 16; fire deaths

were 10; homicides were 38 and suicides were 49 in the 0 to 24 age group.

Data Source Kansas Vital Statistics - Mortality Data, Kansas Department of Health and Environment

Progress/Trends From 1992-94, injury deaths accounted for 45% of child, adolescent and young adult morbidity for Kansans 0 through 24 years of age. Of all injury deaths, 63.5% were unintentional injuries, followed by suicides (19.6%) and homicides (16.9%). From 1992-94, motor vehicle accidents (MVAs) were the leading cause of unintentional injury deaths to all Kansas youth 0-24 (64.6%), youth in the 15-24 age group (78.2%, n=355) and youth 5-14 (52.1%, n=61). The number of MVA deaths among Kansas youth have **not maintained a steady direction** between 1990 through 1995. National studies indicate that children in the 5- to 9-year-old age group, are the highest risk group for pedestrian deaths. Pedestrian fatalities to children younger than five years tend to occur when a child is backed over in a home driveway by a vehicle driven by a parent, while fatalities to older children are often the result of “dart-outs” into traffic. Bicycle death rates tend to rise rapidly from the age of 4 and peak for 13-year-old males.

Drowning and fire injury deaths have been on a **steady decline** since 1990. From 1992-94, most injury deaths due to fire/flame occurred to Kansas children 1-4 years (38.9%), followed by youth 5-14 years (30.6%). Fire and burns are the leading cause of fatal injury in the home. From 1992-4, drowning/submersion accidents were the leading cause of unintentional injury deaths to children 1-4 years (31.2%, n=24). Most deaths due to drowning/submersion occurred to youth 15-24 years (42.4%). A large percentage of drownings of young children occurs in residential swimming pools. The danger of a child’s drowning increases with the number of children present because of the difficulty in supervising several children simultaneously.

1. The National MCH Goal is a 15% reduction (Goal specifies unintentional only).
2. The National MCH Goal incorporates four HP 2000 unintentional injury objectives: (a) reduce deaths among children aged 14 and younger caused by motor vehicle crashes to no more than 4.4 per 100,000; (b) reduce deaths among youth aged 15-24 caused by motor vehicle crashes to no more than 26.8 per 100,000; (c) reduce drowning deaths among children aged 4 and younger to no more than 2.3 per 100,000; and (d) reduce residential fire deaths among children aged 4 and younger to no more than 3.3 per 100,000.

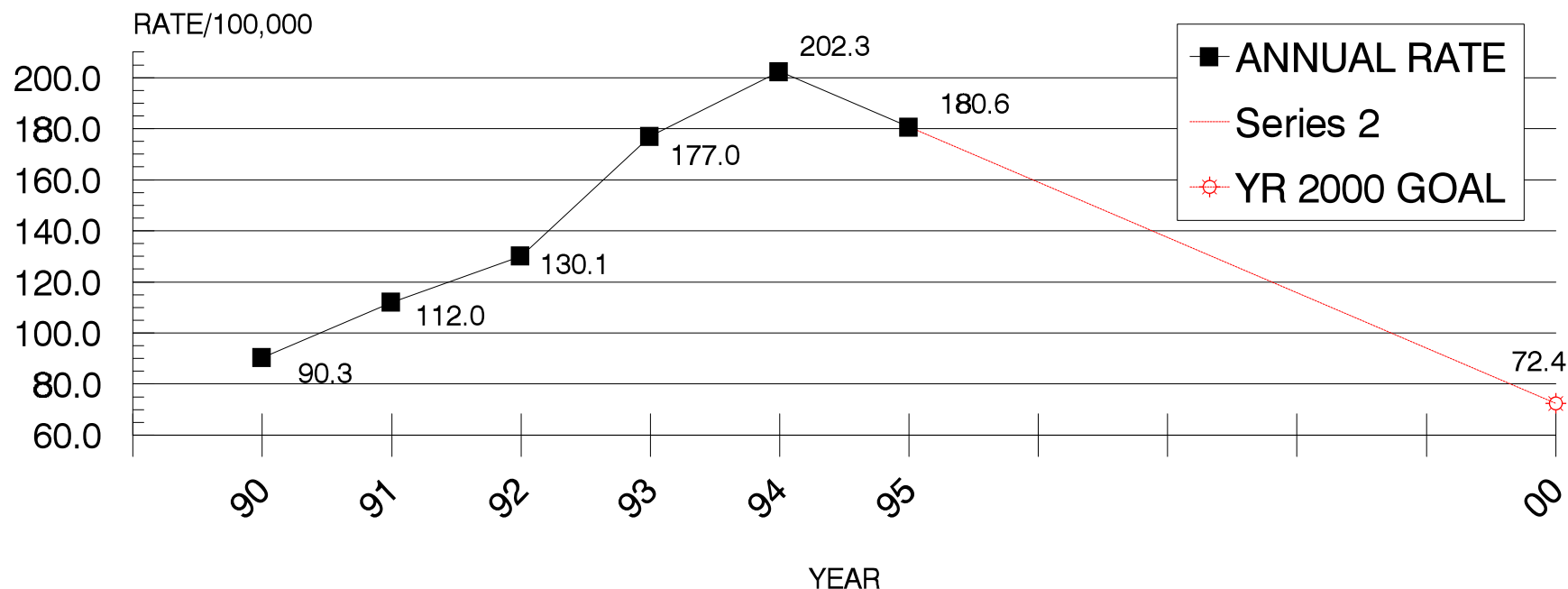
HOMICIDE-BLACK MALE YOUTH

KANSAS OBJECTIVE	Reduce homicides among Black males aged 15-34 to no more than 72.4 per 100,000.
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Significance Homicide is a fatal injury purposefully inflicted by another person, not including deaths caused by law enforcement officers or legal execution. Victims of murder are most likely to be young males who are frequently members of minority group members, particularly Blacks and Hispanics, and who usually know their killers. Intrafamilial homicide accounts for approximately one out of six homicides, primarily among young adults and Blacks. Homicide differentiates Black Americans from other Americans more than any other cause of death and is the leading cause of death for Blacks aged 15-34. Although the largest number of homicides occurs among Whites, more lives are lost to homicide among Blacks 15-34 years of age than to any other cause of death, including suicide, heart disease and cancer. Black male death rates from homicide far exceed the rates from other citizens of the same age and gender with mortality rates 5 to 12 times greater than those of White males. Generally, most homicides are committed with a firearm, occur during an argument, among people who are acquainted with one another and among members of the same race. Alcohol and drug consumption are associated with adolescent and adult homicides. The interrelated effects of both poverty and interpersonal violence, including homicide, can be seen in the homicide statistics for the Black community. Research findings reveal that when socioeconomic status is taken into consideration, the disparity between Black Americans and the general population as both victims and perpetrators of violence lessens. Thus, although race is associated with violence, socioeconomic status is the more indicative risk factor. Unfortunately, national data sources for homicide do not include socioeconomic information on decedents, making progress toward reducing homicide in impoverished groups difficult.

PREVALENCE RATE OF HOMICIDES among Black males aged 15-34

Kansas Goal for the Year 2000: 72.4 per 100,000 Black Males 15-34



Data Source: Kansas Vital Statistics, Mortality Data

National MCH Goal = 72.4 per 100,000; national objective is an age-adjusted rate

Kansas data are crude rates Note: Rate does not include legal intervention homicides

Baseline Data In 1990 there were 25 Black male deaths in the 15-34 year age group due to homicides. This is a rate of 90.3 per 100,000 Black males 15-34 years of age.

Data Source Kansas Vital Statistics - Mortality Data, Kansas Department of Health and Environment

Progress/Trends Since the baseline year, this objective has seen **evident movement in the wrong direction** from the Year 2000 target. According to a 1995 study, *Maternal and Child Health Needs Assessment for Kansas* (Jerome, et. al., Kansas City, Ks : University of Kansas Medical Center Project Team, Department of Preventive Medicine) approximately 87% of all homicide of Black males ages 15-34 have occurred in four Kansas counties in recent years: Wyandotte, Sedgwick, Shawnee and Geary. Wyandotte county had the highest single county proportion with 50% of the homicides. Over 60% of the Black male homicides from 1989 through 1992 occurred in the 15 to 34 age group.

In 1995, 66 of 75 or 88% of all homicides to males ages 15-34 (not race specific) occurred in five Kansas counties: Wyandotte, Sedgwick, Johnson, Shawnee and Geary. Wyandotte county had the highest single county proportion with 43% of the homicides, followed by Sedgwick county with 28%. Over 61% of male homicides in the 15 to 34 age group occurred to males ages 15 to 24.

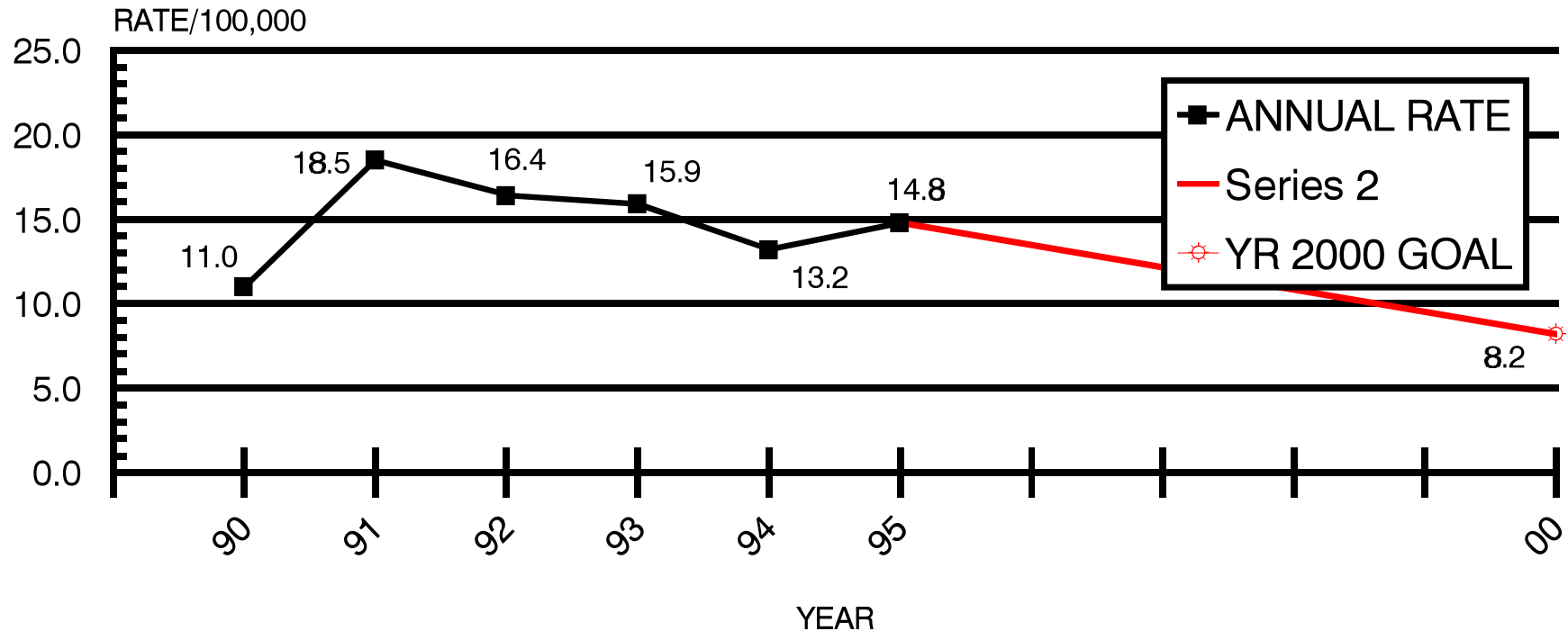
SUICIDE

KANSAS OBJECTIVE	Reduce suicides and the incidence of injurious suicide attempts among youth aged 15 through 19 to no more than 8.2 per 100,000 youth.
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Significance Suicide is the second highest cause of death for Kansans in the 15-24 years age group. While the suicide rate for all age groups has remained stable both nationally and in Kansas for the last fifteen years, there appears to be an epidemic increase in suicide among youth. Traditionally, mental disorders such as various forms of depression, schizophrenia, precipitous life events, family history of suicide or psychiatric disorders, exposure to suicidal behavior, family violence, and availability of firearms in the home are underscored as contributing factors. Some recent research however suggests that most young people at risk for suicide are not depressed but are afflicted by precipitating stressors and some type of personality feature or another co-existing mental disorder. Studies are also examining the relationship between suicide and two widespread phenomena in today's culture: alcohol and firearms. Alcohol or substance use, it is believed, may serve to facilitate the act by reducing inhibitions and impairing a person's judgement. Firearms have become the most customary method used because of the physical availability and sociocultural acceptability. Moreover, firearms are far more likely to be lethal than other methods, consequently the vast majority of attempted firearm-related suicides are completed. Attempted suicides are difficult to track and the data available is less accurate. One reason is that the reporting of suicide attempts is not legally mandated. Estimates are that suicide attempts are eight times more prevalent than completed suicides.

INCIDENCE OF SUICIDES among Adolescents aged 15-19 years

Kansas Goal for the Year 2000: 8.2 per 100,000 (aged 15-19)



Data Source: State Vital Statistics Mortality Data

National MCH Goal = 8.2 suicides per 100,000 (aged 15-19)

Kansas data are crude rates; national objective is an age-adjusted rate

Baseline Data Kansas Death Certificates recorded 96 deaths from suicide among 15-19 year old Kansas residents in the years 1989 through 1992. In 1990, Kansas showed a suicide rate of 11 per 100,000 youth 15-19. Kansas still lacks a statistically representative measurement for adolescent suicide attempts.

Data Source Kansas Vital Statistics - Mortality Data, Kansas Department of Health and Environment

Progress/Trends Kansas appears to be following the national pattern for adolescent suicides. Nationally, firearm suicide rate began a sharp and sustained increase in the 1970s, climbing three times faster than other methods among 15 to 19-year-olds and 10 times faster for 20- to 24-year-olds. Since 1991, adolescent suicides in Kansas have sustained an **overall increase with slight fluctuations** since the baseline year. In 1994, 72% of suicides in the 15 to 24 age group were due to firearms (shot guns, hand guns, hunting rifles and unspecified); 79% of suicides in the 15 to 19 age group were due to the same method. Suicide by hanging strangulation was the second highest method. Of the suicides from 1989 through 1994, approximately 79% were males and 21% were females.

ALCOHOL, TOBACCO AND OTHER DRUGS

KANSAS OBJECTIVE	Reduce by 50% ¹ any use of alcohol, tobacco (cigarettes and smokeless), and marijuana among adolescents in grades 6 through 12. ²
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Significance The use of alcohol and illicit drugs among Kansas adolescents is of great concern not only because of physiological effects on the body, but because of the high risk behaviors that directly contribute to the three leading causes of adolescent mortality: unintentional injury, homicide and suicide. Mind-altering and addictive substances have been shown to jeopardize physical, mental and social development during the formative years and to endanger the successful transition from school to the workplace. Adolescent substance abusers are more likely to engage in irresponsible sexual activity, and increase their chances of exposure to HIV infection, contracting a sexually transmitted disease, or becoming pregnant. Moreover, substance abuse is one of the strongest factors predictive of school failure, violent conduct and criminal behavior. Alcohol, the most frequently used drug among adolescents, is the principal contributor to cirrhosis, one of the leading causes of death in Kansas in the 35-44 year-old age group. It is also a leading cause of preventable birth defects which is of particular concern among pregnant adolescents whose pregnancies must be considered at high risk even without drug involvement. Experimentation with all tobacco is occurring at younger and younger ages and initiation now occurs almost entirely during adolescence. Many adolescents who smoke do not understand the nature of tobacco addiction and are unaware, or underestimate, the important consequences of smoking. Individuals who start smoking early have more difficulty quitting, are more likely to become heavy smokers, and are more likely to develop a smoking-related disease. Tobacco use is a major risk factor for diseases of the heart and blood vessels; chronic bronchitis and emphysema; cancers of the lung, larynx, pharynx, oral cavity, esophagus, pancreas, and bladder; and other problems such as respiratory infections and stomach ulcers. Indisputably, youth who engage in alcohol, tobacco and other drug use during adolescence are more likely to extend their usage (i.e., addiction) into adulthood.

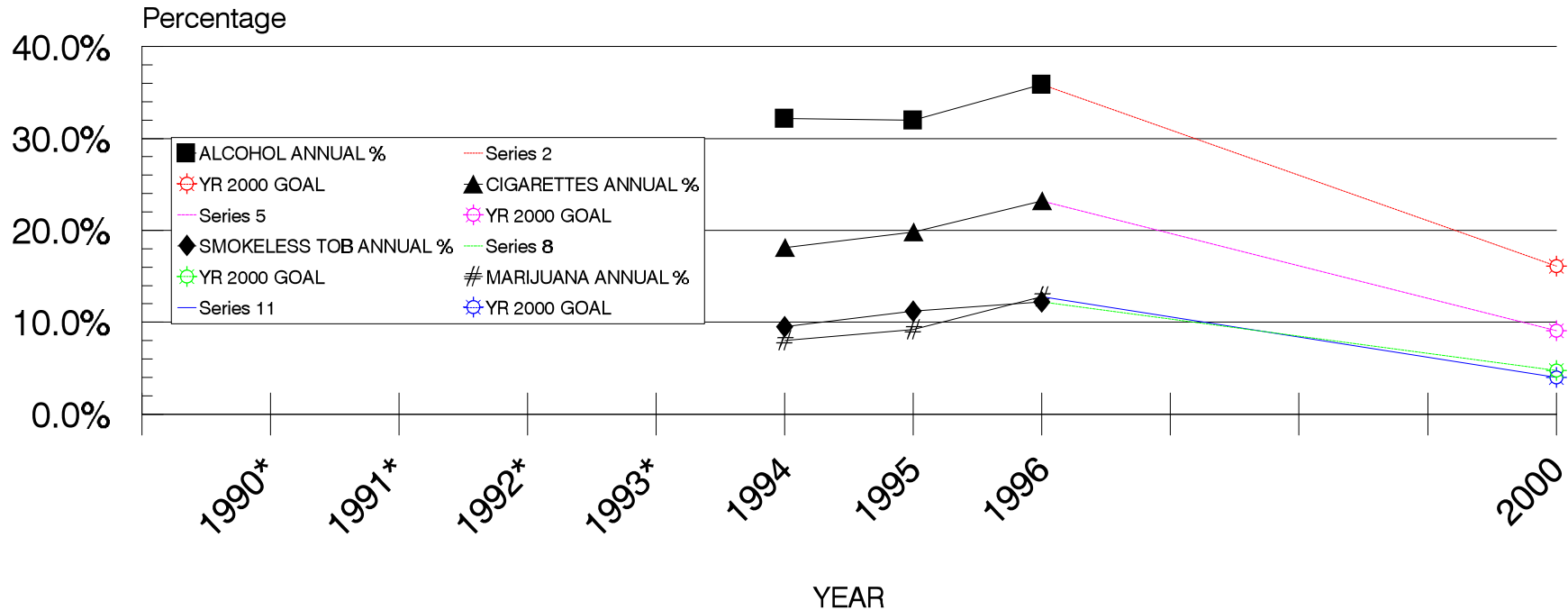
SUBSTANCE USE AMONG KANSAS ADOLESCENTS (grades 6-12)								
% Reporting use within last 30 days	1990	1991	1992	1993	1994	1995	1996	YR 2000 Goal
Alcohol	NA	NA	NA	NA	32.2%	32.0%	35.9%	16.1%
Cigarettes	NA	NA	NA	NA	18.1%	19.8%	23.2%	9.05%
Smokeless Tobacco	NA	NA	NA	NA	9.5%	11.2%	12.2%	4.75%
Marijuana	NA	NA	NA	NA	8.0%	9.2%	12.8%	4.0%

Data Source: Kansas Youth Survey, Alcohol and Drug Abuse Services, SRS

NA =Data not available

USE OF ALCOHOL, TOBACCO AND MARIJUANA among Adolescents in Grades 6 through 12

Kansas Goal = 50% reduction; Track Percentage Annually



Data Source: Kansas Youth Survey (grades 6-12), ADAS/SRS * data not available

Note: Substance Use refers to use of substance (any amount) within the last 30 days

National MCH Goal = 50% reduction; Kansas Year 2000 Goal is 50% reduction of 1994

Baseline Data The 1994 ADAS data indicated adolescents in grades 6 through 12 were using alcohol at a 32.2% proportion, tobacco cigarettes at 18.1%, smokeless tobacco at 9.5% proportion and marijuana at 8.0% proportion.

Data Source Kansas Youth Survey, Adolescent and Drug Abuse Services (ADAS), SRS

Progress/Trends During the 1993-94 school year, ADAS changed the questions in the Kansas Youth Survey in order to compare Kansas data with the Monitoring the Future Survey. The Survey now probes the use of specified substances (alcohol, cigarettes, smokeless tobacco and marijuana) in any amount within the past 30 days.

Viewing the 1996 data obtained through the Kansas Youth Survey, youth reported increased alcohol use, tobacco use, smokeless tobacco use and marijuana when compared to reported use in 1994. Regrettably, this indicates **contrary movement** toward the Year 2000 goal for this objective. In 1996, the use of marijuana surpassed the use of smokeless tobacco for the first time. According to FY96 ADAS data, 57.5 % of 12th graders report use of alcohol within 30 days compared to 45.8% of 10th graders, 25.9% of 8th graders and 8.8% of 6th graders. 12th graders also reported use of cigarettes at a proportion of 33.1% compared to 28.1% of the 10th graders, 18.0% of the 8th graders and 5.1% of the 6th graders surveyed. Use of smokeless tobacco was reported by youth at all grade levels at approximately ½ the proportion of use of cigarettes.

One class of substances not currently being tracked as part of this MCH objective that has become increasingly popular among adolescents is inhalants. One reason for the increase is its accessibility and low cost. Hallucinogens, e.g., lysergic acid diethylamide (LSD), amphetamines, phencyclidine (PCP) and cocaine, is another class of drugs used by adolescents. Since use of these substances by Kansas adolescents is infrequent, they are not currently being tracked.

1. The Kansas Year 2000 Goal is a 50% reduction of the 1990 baseline year as follows: Alcohol 14.6%; Tobacco (cigarettes) 12.7%; Tobacco (smokeless) 7.3%; and Marijuana 6.4%. The use of cocaine which reported an average reported use of 2% is not tracked annually for the Kansas MCH objective.
2. The National Goal is to reduce the proportion of young people 12-17 years who have used alcohol, marijuana, cocaine and cigarettes in the past month. Smokeless tobacco is not included. The Year 2000 Target is a 50% reduction of the 1988 baseline year's proportion.

Every period of life has its peculiar temptations and dangers. But youth is the time when we are the most likely to be ensnared. This, pre-eminently, is the forming, fixing period, the spring season of disposition and habit; and it is during this season, more than any other, that the character assumes its permanent shape and color, and the young are wont to take their course for time and for eternity.

- JOEL HAWES
Cleric

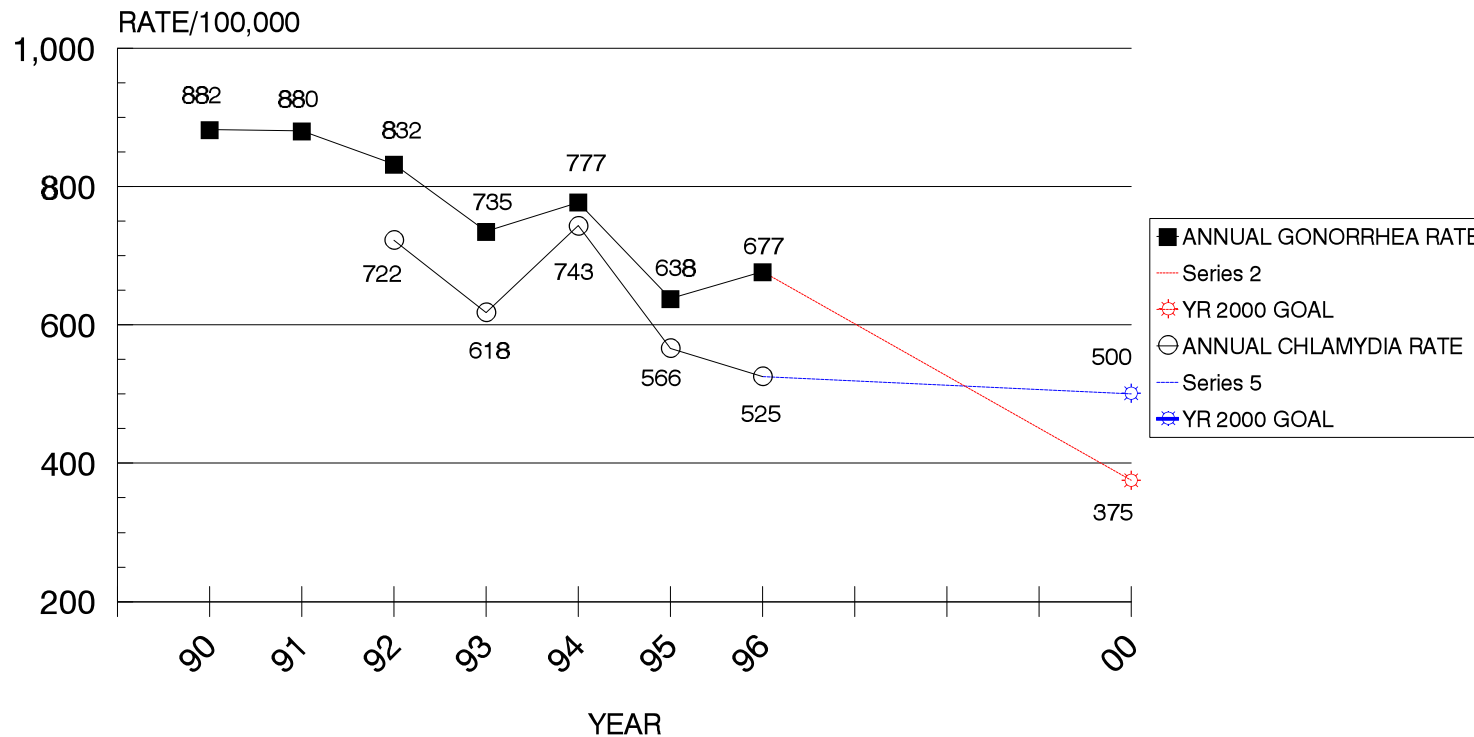
SEXUALLY TRANSMITTED DISEASES

KANSAS OBJECTIVE	Reduce gonorrhea among adolescents aged 15-19 to no more than 375 cases per 100,000 and reduce the prevalence of Chlamydia trachomatis infection among young women 19 years and under to no more than 500 cases per 100,000. ¹
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Significance Sexually transmitted diseases (STDs) are acquired as a result of sexual intercourse with an infected individual. Gonorrhea is a specific, contagious, catarrhal inflammation of the genital mucous membrane of either sex. The disease may also affect other structures of the body such as the heart, conjunctiva, oral mucosa, rectum, or joints. Chlamydia is a genus of microorganisms that cause a wide variety of diseases including trachoma, conjunctivitis and genital infections. Chlamydia and gonorrhea may result in infertility in both males and females, particularly if not diagnosed and treated early. Adolescents and young adults who engage in high risk behaviors (e.g., irresponsible sexual activity and substance abuse) increase the likelihood of contracting a sexually transmitted disease. Proper use of prophylactics may help decrease the risk of catching or spreading STDs but cannot eliminate the risk. Even though both young women and men can suffer serious health problems from a sexually transmitted disease, STDs have a disproportionate impact on women. They are more easily transmitted to women and more difficult to detect. As a result, complications of undiagnosed infections are far more common and severe. Mothers can transmit infections to their offspring during pregnancy or childbirth, sometimes with devastating consequences to the fetus or newborn. When gonorrhea, chlamydia and other sexually transmitted diseases are diagnosed, they are reported to the local public health department and, in turn, to the state's reportable disease registry.

RATE OF SEXUALLY TRANSMITTED DISEASES among Adolescents (Gonorrhea and Chlamydia)

Kansas Goal for the Year 2000: gonorrhea = 375* youth 15-19 yrs; chlamydia = 500** women < 19 yrs



Data Source: State Reportable Disease Registry, Bureau of Disease Prevention and Health Promotion

* per 100,000 youth 15-19 years; ** per 100,000 women 19 years & under

N'tl MCH Goal: gonorrhea [youth 15-19] = 375*; chlamydia [women < 19] = under to no more than 5%**

Baseline Data The 1990 rate of gonorrhea among adolescents 15 to 19 was 882 per 100,000; the 1992 rate of chlamydia among young women ≤ 19 years was 722 per 100,000.

Data Source State Reportable Disease Registry, BDPHP, KDHE

Progress/Trends Every year, about 4000 Kansas adolescents get a sexually transmitted disease. In 1996, adolescents account for 41% of all new Kansas STD cases annually. Despite these circumstances, this objective has shown **substantial progress** since 1991 for both gonorrhea and chlamydia with the exception of 1994. Kansas adolescents 19 and younger accounted for 47% of reported chlamydia cases and 36% of gonorrhea cases in 1996. Whites represented slightly more than 5 in 10 chlamydia cases and Blacks were slightly more than 3 in 10. Among gonorrhea cases, Blacks accounted for 65% with Whites accounting for 28%.

Kansas females outnumber males 5 to 1 in chlamydia cases with a 50/50 female to male split in gonorrhea cases. In 1996, the top five counties in number of chlamydia cases were: Sedgwick (1086), Wyandotte (743), Shawnee (481), Johnson (307) and Geary (255). In contrast, the Northwest Kansas region reported a twelve-county total of only 22 cases. The top five counties in number of gonorrhea cases in 1996 were Wyandotte (594), Sedgwick (585), Shawnee (323), Geary (89) and Johnson (72). Northwest Kansas counties had only two cases while Southwest Kansas had a gonorrhea case count of 29.

1. The National Goal is to reduce the incidence of gonorrhea among adolescents 15-19 to no more than 375 cases per 100,000 and the prevalence of chlamydia trachomatis infections among females 19 years and under to no more than 5%. In addition to gonorrhea and chlamydia, the National Goal includes the reduction of primary and secondary syphilis [HP 19.3], congenital syphilis [HP 19.4], genital herpes and genital warts [19.5] and an increase in condom use among sexually active females and males 15-19 years [HP 19.10a & 19.10b].

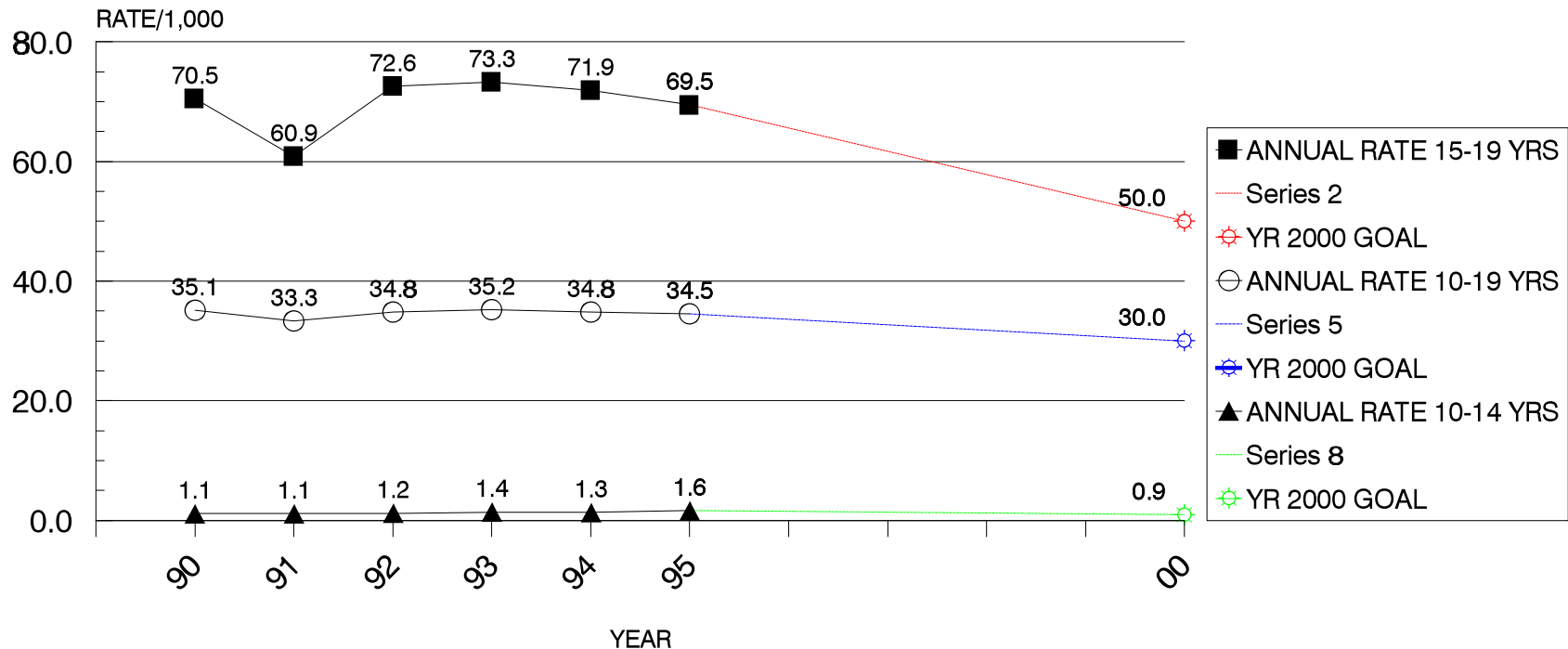
ADOLESCENT PREGNANCY

KANSAS OBJECTIVE	Reduce pregnancies among females aged 10 to 19 ¹ to no more than 30 per 1,000 adolescents.
	Reduce pregnancies among females aged 10 to 17 to no more than 11 per 1,000 adolescents. ²

Significance For a combination of physiological, social, and economic reasons, adolescent childbearing is associated with a variety of negative consequences to both the mothers and their babies. Infants born to adolescent mothers are at increased risk for health, developmental, and academic problems. Since so many adolescents fail to receive early prenatal care and do not receive adequate nutrition, their babies are more likely to be born at low birthweight, a strong predictor of later health problems. Children born to adolescent mothers are more likely to be born premature and to die before they reach their first birthdays. Additionally, they may be at increased risk of neglect, mental retardation, congenital defects, and other handicapping conditions. Children born to adolescents are less likely than other children to adapt well to school and are at increased risk of being educationally and emotionally hampered. Sometimes pregnant adolescents have been sexually or physically abused which can lead to low self-esteem and a sense of hopelessness. Adolescent mothers are often poor and lack the knowledge, skills and social support needed to be good parents as well as the education, training and connection to employment that would enable them to obtain jobs, become self-sufficient and capable of supporting a family.

RATE OF ADOLESCENT PREGNANCIES among Females aged 10-19 years

Kansas Goal for the Year 2000 = 30 per 1,000 females (aged 10-19)

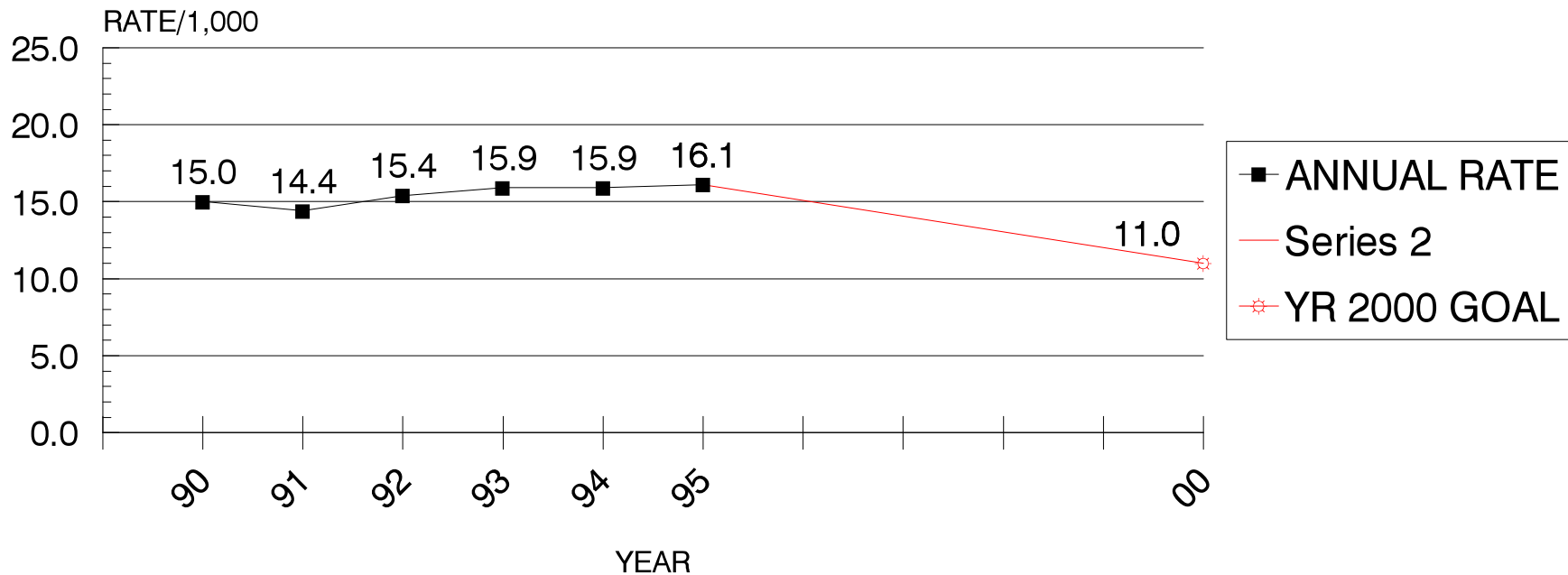


Data Source: Kansas Vital Statistics, Natality Data, Fetal Mortality and Abortion Data

National MCH Goal = 50 per 1,000 females aged 15-17

RATE OF ADOLESCENT PREGNANCIES among Females aged 10-17 years

Kansas Goal for the Year 2000 = 11 per 1,000 females (aged 10-17)



Data Source: Kansas Vital Statistics, Natality Data, Fetal Mortality and Abortion Data

Note: KSA 65-1,158 requires reporting of the annual pregnancy rate for females 10 through 17 years

Baseline Data In 1990, the pregnancy rate for adolescent females was 35.1 per 1,000 females aged 10 to 19 years and 15.0 per 1,000 females 10 to 17 years.

Data Source Kansas Vital Statistics - Natality Data, Fetal Mortality and Abortion Data, Kansas Department of Health and Environment

Progress/Trends The pregnancy rate for youth aged 10-19 had **little fluctuation** from 1990 through 1995. The adolescent pregnancy rate for youth 10-17 has also **remained relatively steady** with a slight rate increase of 1.1 from 1990 (15.0 per 1,000) to 1995 (16.1 per 1,000). The high adolescent pregnancy rate for the 10-19 years age group was 35.2 (1993) and for the 10-17 years age group it was 16.1 (1995). In comparison, for youth aged 15-19, there was a **mixed rate trend** from 1990 through 1995 with a high adolescent pregnancy rate of 73.3 in 1993. The low adolescent pregnancy rate for all three groups (i.e., youth under 18 years, youth aged 10-19 and youth aged 15-19) occurred in 1991. The rates were 14.1, 33.3 and 60.9 respectively.

The adolescent pregnancy rate in Kansas maintains a consistent distance behind the United States adolescent pregnancy rate which exceeded 100 per 1,000 females in both the 10-19 and 15-19 year age groups. The highest for the United States in the 10 to 19 year age group was 113.8 in 1990 decreasing to 111.1 in 1991.

In 1995, of the births to teenage women ages 10 to 19, 81.3% were to Whites and 15.7% to Blacks. Among Hispanic adolescents, who can be of any race, the proportion of total adolescent pregnancies was 9.5%. Also in 1995, of the births to mothers 10-19 years of age where the age of the father is known, just over one-third (36.3%) had fathers who were 10-19 years of age while nearly two-thirds (63.7%) had fathers who were 20 years and over. A comparison of live births by age group also indicates that the ratio of mothers under 18 years of age to fathers in that same age group was 5 to 1. In 1995, the age of more than 4,000 fathers was not stated on the birth certificate compared to only 5 mothers whose age was also not stated.

1. The National Goal is the reduce pregnancies among females aged 15-17 to no more than 50 per 1,000 adolescents.
2. K.S.A. 65-1,158 enacted July 1, 1991 and entitled COMMUNITY-BASED TEENAGE PREGNANCY REDUCTION PROGRAM requires that grant proposals include the annual pregnancy rate for females who are 10 through 17 years of age.

The problems of adolescence deal
with deep and moving human experiences.
They center on a fateful time in the life course
when poorly informed decisions
can have lifelong consequences.
The tortuous passage from childhood to adulthood
requires our highest attention,
our understanding
and a new level of thoughtful commitment.

- DAVID A. HAMBURG
President
Carnegie Corporation of New York

SYSTEMS DEVELOPMENT

KANSAS OBJECTIVE	Establish a statewide network of comprehensive, community-based health care systems that serve women of reproductive age, infants, children, adolescents, and children with special health care needs; the systems will assure family-centered, culturally-competent, coordinated, accessible services. ¹
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Significance The establishment of systems of service that reflect the principles of comprehensive, community-based, coordinated, family-centered, culturally-competent and accessible health care is essential to assure the well-being of Kansas children and families. A comprehensive system of services is defined as a broad range of health, educational, social and related services in delivering care. The system encompasses preventive, primary, secondary, and tertiary health care and addresses physical health, mental health, oral health, nutrition, health promotion, monitoring of development, parent/patient guidance, early intervention, and family planning. It also addresses needs for emergency medical services, substance use/abuse services, specialized mental health services, educational services, vocational services, social services, recreational services, and family support services.

A coordinated system of services is defined as multiple services provided by different providers in a timely, complementary, consistent manner, in proper sequence and utilizing all existing resources. In addition, the array of services should assure appropriateness, continuity, and completeness of care. A community-based system of services is defined as services delivered at the local level or as close to the family's home as possible; the major responsibility for planning, designing, and implementing the services rests within the community as defined by the family. The system of care draws from the community to meet the family's health needs. The area encompassed by the community will depend on a number of factors including population density, political divisions, existing arrangements for provision of services, and availability of resources. A family-centered system of care is defined as care, across disciplines and settings, that recognizes and respects the pivotal role of the family in the lives of the client. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family/professional collaboration and choice in the provision of services to the family. It recognizes and builds on individual and family strengths, and respects the diversity of families. A culturally competent system of services is a system that advances a provider's ability to honor the beliefs, interpersonal styles, attitudes and behaviors of families who are clients and the multicultural staff who are providing services by incorporating them in policy, administration, and practice. Moreover, the system recognizes that culture is heterogeneous in terms of ethnic, racial, spiritual, social, economic, educational and geographic diversity. An accessible system of services is multidimensional and encompasses these attributes: availability, geographic accessibility, accommodation, affordability, and acceptability.

Baseline Data	Baseline data is needed to determine current status and track future progress.
Data Source	Not applicable.

Progress/Trends	Kansas has acknowledged the importance of assessing a statewide health care
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system for women and children, including children with special health care needs, and **acquiring baseline data to determine current systems response**. Kansas' highest MCH priority is the assurance of services to mothers and children, including children with special health care needs, many of whom have no alternative source of care. For these Kansans especially, a statewide MCH services network is essential. Application of systems development in the activities of the Maternal and Child Health program in Kansas is an ongoing process. These systems development activities relate to building service capacity and improving interactions among agencies, services and persons that provide needed care to Kansas children and families so that care is more effective and humane.

In addition to assuring services at the community level, there are a number of state-level accomplishments for Kansas: 1) Health Advisory Coalition for Children, Youth and Families (HACCYF) conferences and recommendations; 2) implementation of the AAP/APHA guidelines for health and safety in child care settings in conjunction with the Bureau of Adult and Child Care Licensing, KDHE; 3) initiation of the development of systems measures in consultation with Health Systems Research, Inc.; 4) continuing review of state data systems and capacity with administrative and other support to implement recommendations; and 5) review of state financing mechanisms with administrative support for staffing to pursue alternatives.

Three recent MCH initiatives include: 1) consolidation of several categorical grants (M & I, HSHV, CH and FP) with twelve local agencies moving to "systems funding" for the provision of core MCH services; 2) support to the Bureau of Local and Rural Health Services (BLRHS) in providing technical assistance to local agencies undertaking a Comprehensive Health Assessment Process (CHAP) with emphasis on the 18 MCH Select Objectives; and, 3) participation in initial meetings focused on modification of managed care to modulate the development of capitated managed care programs for selected Medicaid populations. By maintaining routine dialogue with Medicaid and private insurance representatives, BCYF has addressed concerns and scrutinized solutions in areas of drive-through deliveries, well-child care and immunizations.

1. The National Goal is to establish a statewide network of comprehensive, community-based systems of health and related services for women of reproductive age, infants, children, adolescents, and children with special health care needs to assure family-centered, culturally-competent, coordinated services and increase the number of states that have services systems for children with or at risk of chronic and disabling condition, as required by Public Law 101-239 (related to H.P. 17.20).

Today people with widely divergent
ideologies can meet on the common
ground that the family is central,

but,

to assure that children grow
into sturdy adults, the family
needs to be buttressed
by social institutions, including
churches, schools, community
agencies - and government.

- LISBETH SCHORR,
*Within Our Reach: Breaking
the Cycle of Disadvantage*

The correlation between poor health
and lower socio-economic status
has been well-documented,
but that doesn't make it right or inevitable.
Good health should not be seen, or,
for that matter, be permitted to exist in fact,
as a benefit for only those who can afford it,
it should be available and accessible
to every citizen.

- LOUIS W. SULLIVAN, M.D.
Secretary of Health and Human Services
In Foreward, *Healthy People 2000*, 1990

We cannot afford to continue to ignore child poverty.
Our high child poverty rate is interfering
with the healthy development and education
of millions of our children
and threatens the nation's economic and social future.

High child poverty rates are making it far more difficult and expensive
to solve a host of related social problems
afflicting children, their families and the nation.
Eliminating child poverty will give the nation
a running start on tackling
the educational, health, substance abuse, crime,
and other problems that seem so daunting.

- MARIAN WRIGHT EDELMAN
Child Poverty in America,
1991

CHILDREN IN POVERTY

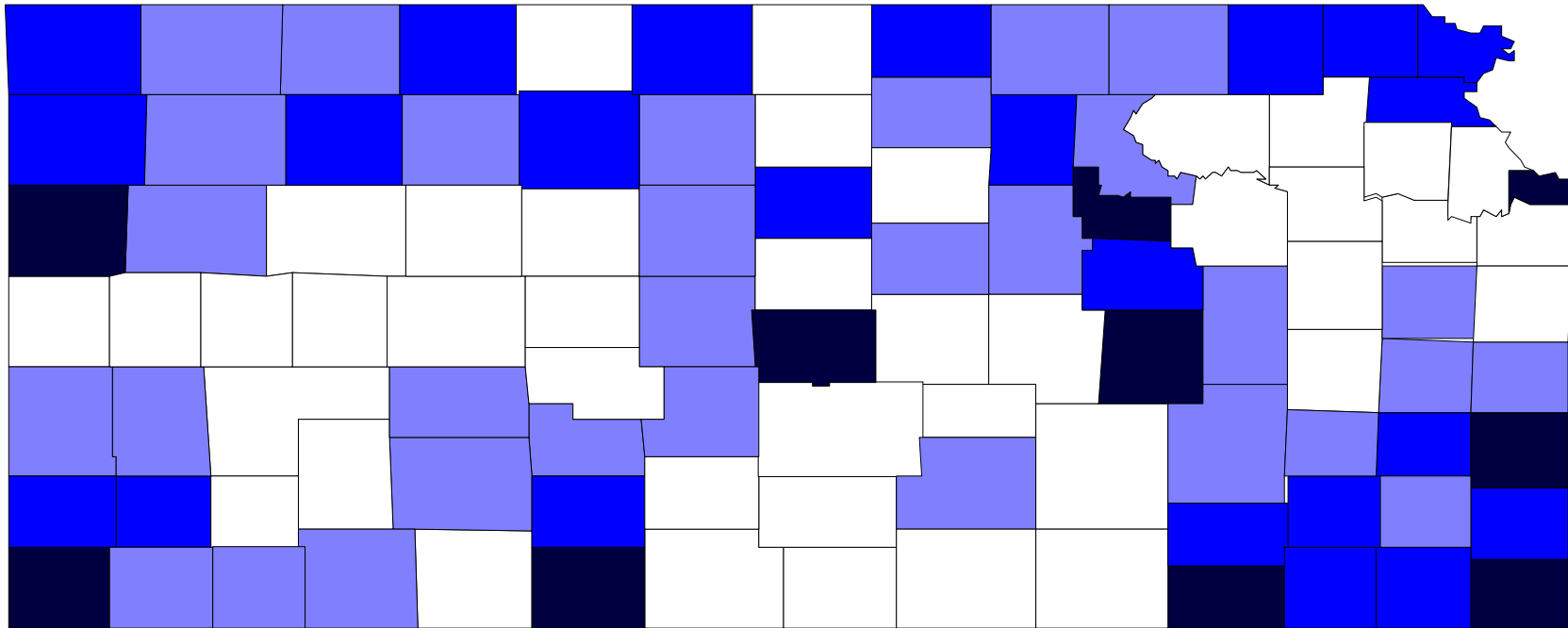
KANSAS OBJECTIVE	Decrease the proportion of children and youth living in poverty to less than 10 percent.
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Significance Research shows that poverty is associated with poor health and inadequate health care for women, infants and children. Poor women are less likely to receive prenatal care and are more likely to give birth to babies born too small or too soon. Poor infants are more likely to die before reaching their first birthdays. Children from low-income families have increased risk of being inadequately immunized against preventable childhood diseases, are more likely to suffer from problems related to inadequate nutrition, such as hunger, undernourishment, growth stunting or iron-deficiency anemia and more apt to contract bacterial meningitis. Other adverse outcomes suffered disproportionately by low-income children include physical impairment (e.g., severely impaired vision), complications of illnesses, abuse, neglect, and illness and injury resulting in premature death. Poor children miss more days of school due to illness and injury, are more frequently hospitalized and are more likely to be disabled than their non-poor peers. Primary health care, which should help to alleviate some of the harmful effects of child poverty, is more difficult for low-income families to access due to lack of or limited transportation options, insufficient health insurance, low health provider availability and continuity, and possible barriers to the parent, including cultural, linguistic, and educational.

Children from low income families are at higher risk of exposure to environmental circumstances that produce adverse health effects and are more susceptible to poor outcomes from these exposures. Poor children are more likely to live in toxic neighborhoods and suffer from lead poisoning, usually due to ingestion of paint chips, and less commonly from contaminated water in lead pipes and breathing lead paint dust in the air. Consequences to children increase further when families are unable to afford learning materials such as stimulating learning toys, children's books, or school supplies; good quality child care; decent, stable housing; or the hope of living outside a crime-ridden neighborhood.





The newly enacted welfare reform initiatives will have great implications on children's health. Without traditional supports such as quality day care, affordable housing, nutrition, health care and adequate income (whether cash or vouchers) to replace welfare, experts from the Center for Health Policy Research predict there will be an increase in adverse poverty-related child health outcomes - all in an attempt to help welfare recipients become self-sufficient. It is estimated that within six years many more families will be pushed into poverty due to federal cuts and changes in welfare, Supplemental Security Income, child support enforcement, immigration, child care, food stamps, social services, earned income tax credit and Medicaid.

Percent of Children in Poverty by County in Kansas

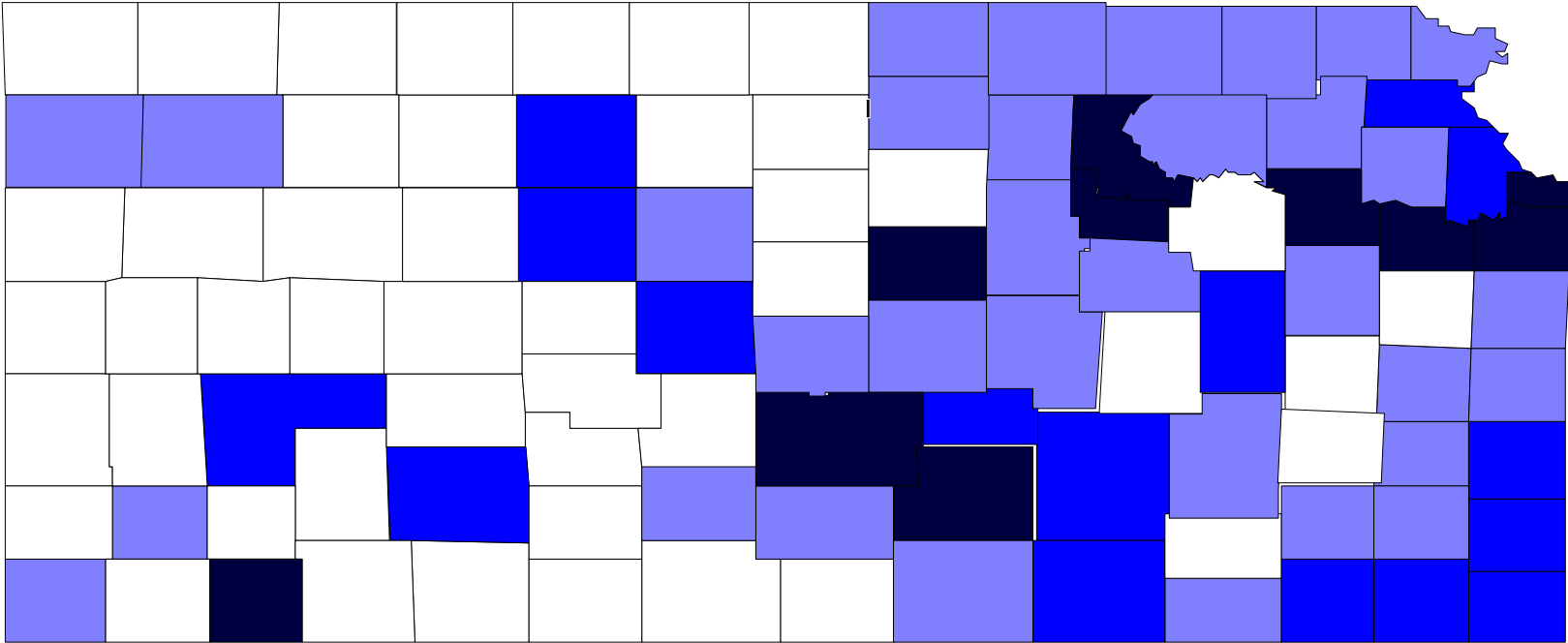


Kansas Department of Health and Environment
Children and Families Section (913) 296-1307
11/96

Source: 1990 U.S. Census

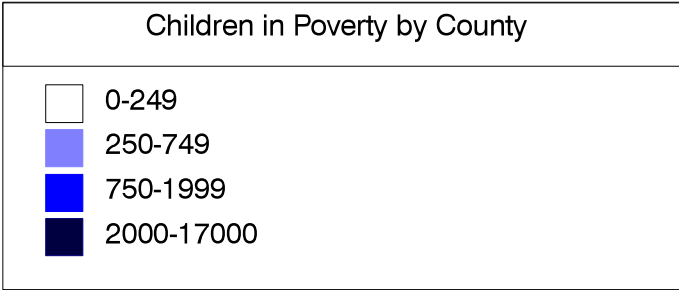
Children in Poverty by County	
	3.4-13.9%
	14.0-17.8%
	18.1-21.7%
	22.9-30.2%

Number of Children in Poverty by County in Kansas



Kansas Department of Health and Environment
Children and Families Section (913) 296-1307
11/96

Source: 1990 U.S. Census



Baseline Data Based on 1969 income, the number of all persons younger than 18 in Kansas who were poor was 88,659 or 12.0% of that age cohort.¹ Of those children, 28,462 were under six years. This means 13.4% of Kansas children younger than six were living in poverty in 1969.

Data Source U.S. Department of Commerce, Bureau of the Census, 1990 Census of Population and Housing, Table 9. Income and Poverty Status in 1989.

Also in 1969, 71,481 or 10.4% of White children younger than 18 lived below the poverty level in Kansas. Of those children, 22,791 were under six years. This means 11.6% of Kansas White children younger than six were living in poverty in 1969. In 1969, 38.2% of Black children in Kansas younger than 18 (N=16,047) lived below the poverty level. Of those children, 5,371 or 40.1% were under six years.

Progress/Trends During the 70's, child poverty for all Kansas children under 18 years decreased moderately in number (72,995) and slightly in proportion (11.4%). This also pertains to both the White and Black populations in Kansas in 1979. The number of White children under 18 years in poverty in 1979 was 52,779 or 9.2%. The number of impoverished Black children under 18 in 1979 was 14,549 or 33.6%. For all Kansas children under six years, there was no significant change in either the number or percent living in poverty (N=28,345; 13.4%). There was a decrease of over 18,000 in the number of impoverished White children under six years in 1979. The proportion decreased to 9.2%. The number of Black children under six below the poverty level in 1979 was only slightly lower (5,371 or 39.6%).

Unfortunately, during the 80's child poverty escalated. In the current decade, the Children in Poverty objective is indicating **movement in the wrong direction** rather than progress toward the Year 2000 target. In 1989, Kansas child poverty for all Kansans younger than 18 increased to 90,962. This means that 13.9% of all Kansas children under 18 were living in poverty. Of that number, 11.2% or 63,603 were White children and 40.0% or 18,359 were Black children. As in the case of the under 18 age cohort, child poverty for the under six population drastically increased as well in 1989. Kansas child poverty for all Kansans younger than six was 37,548 or 16.8%. Of that number, 13.6% or 26,378 were White children and an alarming 45.6% or 7,695 were Black children.

According to the 1990 census, Kansas counties with the highest number of children in poverty were: Sedgwick (16,355), Seward (13,819), Wyandotte (11,328), Shawnee (5,563), Johnson (3,682), Riley (2,349), Douglas (2,157), Saline (2,037), Reno (2,026), and Geary (2,026). Counties with the lowest number of children in poverty were located primarily in the Southwest Kansas region. Kansas counties with the highest percent of children in poverty were: Cherokee (30.2%), Wallace (29.5%), Chautauqua (26.8%), Wyandotte (25.1%), Morton (24.6%), Bourbon (24.2%), Chase (23.9%), Rice (23.8%), Comanche (23.5%), and Geary (22.9%). Counties with the lowest percent of children in poverty were located primarily in the Northeast and Southcentral Kansas regions.

1990 Census data in Kansas also indicates that 50.6 percent of children under age five in single-parent families are living in poverty. Forty percent of children under 18 years in poverty are under the care of a female householder with no husband present. In addition, 59.1 percent of Kansas poor children live in a family with at least one worker.

A national study published in the October 1996 issue of *American Journal of Public Health* determined that the rise in child poverty is primarily the result of the overall decline of the income of fathers and the contributing factors of unemployment and underemployment. According to the study, the poverty rate for children in single mother families is more than five times the rate for children in two-parent families. The article cites other national studies that offer these contributing factors: (1) women's economic status is affected more by marital disruption than men's, (2) women usually have the care of dependent children, (3) women earn much less than men, and (4) women frequently do not receive any child support payments.

1. Percent of Children in Poverty is the percentage of related children under 18 years of age who live in families with incomes below the U.S. poverty threshold, as defined by the U.S. Bureau of the Census.

APPENDICES

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APPENDIX A

1997 Summary List of the 18 Selected National Objectives with 2 additional Kansas-Selected Objectives [◆]

The Maternal and Child Health Bureau selected the following 18 national objectives from Healthy People 2000 [H.P.] to track because of their focus on:

- preventing disability or premature death,
 - reducing poverty, and
 - promoting improved health status and health services systems development.
1. Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. [H.P. 14.11]
 2. Confine the prevalence of HIV infection among women giving birth to live-born infants to no more than 100 per 100,000. [H.P. 18.2c]
 3. Reduce low birth weight to an incidence of no more than 5 percent of live births and very low birth weight to no more than 1 percent of live births. [H.P. 14.5]
 4. Increase to at least 95 percent the proportion of newborns screened by State-sponsored programs for genetic disorders and other disabling conditions and to 90 percent the proportion of newborns testing positive for disease who receive appropriate treatment. [H.P. 14.15]
 5. Reduce the infant mortality rate to no more than 7 per 1,000 live births, the neonatal mortality rate to no more than 4.5 per 1,000 live births and, the postneonatal mortality rate to no more than 2.5 per 1,000 live births. [H.P. 14.1]
 - ◆ Increase to at least 75% the proportion of women who exclusively or partially breastfeed their babies in the early postpartum period and to at least 50% the proportion who continue breastfeeding until their babies are 5 to 6 months old. [H.P. 2.11, same as 14.9]
 6. Reduce the average age at which children with significant hearing impairment are identified to no more than 12 months. [H.P. 17.16]
 - ◆ Increase to at least 95% the proportion of EPSDT eligible children who participate in the full complement of EPSDT services, including physical health, mental health, oral health, vision and hearing, all periodic screening as recommended by the American Academy of Pediatrics, any indicated screening, and all needed diagnosis and treatment. [related H.P. 17.15]
 7. Increase the proportion of children under age 2 who complete the basic immunization series to at least 90 percent. [H.P. 20.11]
 8. Reduce the prevalence of elevated levels of blood lead exceeding 15 µg/dL and 25 µg/dL among children aged 6 months-5 years to no more than 300,000 and zero, respectively. [H.P. 11.4]
 9. Increase to at least 50 percent the proportions of children who have received protective sealants on the occlusal surfaces of permanent molar teeth. [H.P. 13.8]

10. Reverse to less than 22.6 per 1,000 children the rising incidence of maltreatment of children younger than age 18 (includes physical abuse, sexual abuse, emotional abuse, or neglect). [H.P. 7.4]
11. Reduce by 15% deaths among children and adolescents caused by unintentional injuries (including motor vehicle crashes, motorcyclists, bicyclists, and pedestrians; drowning deaths; and residential fire deaths). [H.P. 9.3-9.6]
12. Reduce homicides among Black males aged 15-34 to no more than 72.4 per 100,000. [H.P. 7.1c]
13. Reduce suicides and the incidence of suicide attempts among youth aged 15 through 19 to no more than 8.2 per 100,000 youth. [H.P. 7.2, 7.8]
14. Reduce the proportion of young people 12-17 years who have used alcohol (12.6%), marijuana (3.2,%), cocaine (0.6%) and cigarettes (6.0%) in the past month. [H.P. 3.5 and 4.6]
15. Reduce the proportion of youth who contract sexually transmitted diseases: Gonorrhea - 375 cases per 100,000 youth 15-19 and Chlamydia - 5% prevalence among females 19 years and younger. STDs can also include primary and secondary syphilis, congenital syphilis, genital herpes and genital warts. Increase condom use at last intercourse to 50% proportion for sexually active females 15-19 years, 75% proportion for sexually active males 15-19 years. [H.P. 19.1-19.5, 19.10]
16. Reduce pregnancies among young females aged 15-17 years to no more than 50 per 1,000 adolescents. [H.P. 5.1]
17. Establish a statewide network of comprehensive, community-based systems of health and related services for women of reproductive age, infants, children, adolescents, and children with special health care needs to assure family-centered, culturally-competent, coordinated services and increase the number of states that have services systems for children with or at risk of chronic and disabling condition, as required by Public Law 101-239. [H.P. 17.20]
18. Through these efforts and others, decrease the proportion of children and youth living in poverty to less than 10 percent.

Note: In addition to the 17 Healthy People 2000 objectives, MCHB identified reducing poverty as a significant underlying objective. This reflects the substantial effect that poverty plays in diminishing health status as any single change in health services or population-based public health activities. While State MCH programs cannot use Title V resources directly to reduce poverty, they can promote social supports that alleviate poverty and encourage community and State efforts to link health programs with activities that promote economic development and personal financial well-being.

APPENDIX B

Table 1: Kansas' Priority MCH Objectives

KANSAS' PRIORITY MCH OBJECTIVES FOR THE YEAR 2000:	MCHB PRIORITY FOCUS AREAS			HP 2000 PRIORITY AREAS	HP 2000 OBJECTIVE TYPE		
	PREVENTING [DISEASE], DISABILITY OR PREMATURE DEATH	REDUCING POVERTY AND PROMOTING HEALTH SERVICES SYSTEMS DEVELOPMENT	PROMOTING IMPROVED HEALTH STATUS		HEALTH STATUS	RISK REDUC-TION	SERVICES AND PROTECTION
1 PRENATAL CARE		✓		MATERNAL & CHILD HEALTH			✓
2 HIV INFECTION - WOMEN	✓			HIV INFECTION		✓	
3 LBW & VLBW	✓			MATERNAL & CHILD HEALTH		✓	
4 NEWBORN SCREENING		✓		MATERNAL & CHILD HEALTH			✓
5 INFANT MORTALITY RATE; NNMR;PNMR			✓	MATERNAL & CHILD HEALTH	✓		
♦ KS SELECT: BREASTFEEDING	✓			NUTRITION also MATERNAL & CHILD HEALTH		✓	

	MCHB PRIORITY FOCUS AREAS			HP 2000 PRIORITY AREAS	HP 2000 OBJECTIVE TYPE		
KANSAS' PRIORITY MCH OBJECTIVES FOR THE YEAR 2000:	PREVENTING [DISEASE], DISABILITY OR PREMATURE DEATH	REDUCING POVERTY AND PROMOTING HEALTH SERVICES SYSTEMS DEVELOPMENT	PROMOTING IMPROVED HEALTH STATUS		HEALTH STATUS	RISK REDUC- TION	SERVICES AND PROTECTION
6 HEARING IMPAIRMENT		✓		CHRONIC DISABLING CONDITIONS			✓
♦ KS SELECT: EPSDT PARTICIPATION	✓			related to: CHRONIC DISABLING CONDITIONS		✓	
7 IMMUNIZATIONS	✓			IMMUNI ZA- TIONS		✓	
8 BLOOD LEAD LEVELS			✓	ENVIRON- MENTAL HEALTH	✓		
9 DENTAL SEALANTS	✓			ORAL HEALTH		✓	
10 CHILD MALTREATMENT			✓	VIOLENT & ABUSIVE BEHAVIOR	✓		
11 CHILD & YOUTH INJURY DEATHS (UNINTENTIONAL & INTENTIONAL)			✓	UNINTEN- TIONAL INJURIES	✓		

	MCHB PRIORITY FOCUS AREAS			HP 2000 PRIORITY AREAS	HP 2000 OBJECTIVE TYPE		
KANSAS' PRIORITY MCH OBJECTIVES FOR THE YEAR 2000:	PREVENTING [DISEASE], DISABILITY OR PREMATURE DEATH	REDUCING POVERTY AND PROMOTING HEALTH SERVICES SYSTEMS DEVELOPMENT	PROMOTING IMPROVED HEALTH STATUS		HEALTH STATUS	RISK REDUC- TION	SERVICES AND PROTECTION
12 HOMICIDE - BLACK MALE YOUTH			✓	VIOLENT & ABUSIVE BEHAVIOR	✓		
13 ADOLESCENT SUICIDE			✓	VIOLENT & ABUSIVE BEHAVIOR	✓		
14 ADOLESCENT SUBSTANCE USE (ALCOHOL, TOBACCO & OTHER DRUGS)	✓			TOBACCO; ALCOHOL & OTHER DRUGS		✓	
15 STDs AMONG ADOLESCENTS			✓	SEXUALLY TRANSMITTED DISEASES	✓		
16 ADOLESCENT PREGNANCY			✓	FAMILY PLANNING	✓		
17 MCH SYSTEMS DEVELOPMENT		✓		CHRONIC DISABLING CONDITIONS			✓
18 CHILDREN IN POVERTY		✓		[HP 2000 N/A]			✓

Table 2: Progress on 20 Kansas Priority MCH Objectives

OBJECTIVE	BASELINE	'96 UPDATE	YEAR 2000 TARGET	MET GOAL/ RIGHT DIRECTION	WRONG DIRECTION	MIXED/ NO CHANGE	NO DATA/ CANNOT ASSESS
PRENATAL CARE	89/ 80.3%	95/ 85.3%	90%	✓			
HIV INFECTION	90/ Rate = 18	94/ 29.5	12				✓ suspended
LBW & VLBW	89/ LBW=6.1	95/ 6.4	5.0			✓	
	VLBW=1.1	1.1	1.0			✓	
NEWBORN SCREENING	93/ TRACK=Y	95/ TR=Y	TR=Y	✓			
	FLW-UP=Y	FL-UP=Y	FL-UP=Y	✓			
IMR	88/ IMRate=7.9	95/ 6.9	7.0	✓			
	NIMR=5.0	4.5	4.5	✓			
	PIMR=3.3	2.4	2.4	✓			
BREAST- FEEDING	88/ Int.=36.5%	95/ 67.5%	75.0%	✓			
	Cont.=3.0%	37.7%	50.0%	✓			
HEARING IMPAIR.	95/ estmt=81%	same	90%				✓ 1 yr data
EPSDT PART.	90/ 14%	95/ 65%	90%	✓			
IMMUNIZA- TIONS	90-91/ 51.3%	95-96/ 59.1%	90%	✓			
BLOOD LEAD LEVELS	94/Rate ≤ 10 µG/dL = 388.0	95/ 451.1	232				✓ 2 yrs data
	≤ 15 µG/dL = 135.8	174.5	81				✓ 2 yrs data
DENTAL SEALANTS	No baseline						✓
CHILD ABUSE & NEGLECT	93/ Reported= 36.3	95/ 44.1	35.3		✓		
	Confirmed= 4.0	4.7	3.7		✓		

OBJECTIVE	BASELINE	'96 UPDATE	YEAR 2000 TARGET	MET GOAL/ RIGHT DIRECTION	WRONG DIRECTION	MIXED/ NO CHANGE	NO DATA/ CANNOT ASSESS
INJURY DEATHS	90/ MVAs=179	95/ 135	152.2	✓			
	Drowning=1 6	5-year = 15	13.6			✓	
	Fire = 10	5-year = 10.2	8.5			✓	
	Homicide= 38	74	32.3		✓		
	Suicide=49	71	41.7		✓		
BLACK MALE HOMICIDE	89/ Rate = 112	95/ 180.6	72.4		✓		
SUICIDE	90/ Rate-11	95/ 14.8	8.2		✓		
ATODs	94/ Alcohol =32.2%	96/ 35.9%	16.1%		✓		
	Cigarettes =18.1%	23.2%	9.05%		✓		
	Smokeless Tob= 9.5%	12.2%	4.75%		✓		
	Marijuana = 8.0%	12.8%	4.0%		✓		
STDs	90/Rate Gonorrhea= 882	96/ 677	375	✓			
	92/Rate Chlamydia= 772	96/ 525	500	✓			
PREG- NANCY	90/Rate 10-19 yrs = 35.1	95/ 34.5	30.0			✓	
	90/Rate 10- 17 yrs = 15.0	95/ 16.1	11.0			✓	
SYSTEMS DEVELOP- MENT	No baseline						✓
POVERTY	70/Number Ttl=88,659	90/ N=90,624	N/A		✓		
	Percent Ttl=13.4%	90/13.9%	< 10%		✓		

APPENDIX C

ACRONYMS

ADAS	Alcohol and Drug Abuse Services
AIDS	Acquired Immunodeficiency Syndrome
AMCHP	Association of Maternal and Child Health Programs
AZT	zidovudine
BCYF	Bureau for Children, Youth and Families
CDC	Centers for Disease Control and Prevention
CDR	State Child Death Review
CH	Congenital Hypothyroidism
CHANP	Child Health Assessment Nurse Providers
CSHCN	Children with Special Health Care Needs
EDS	Electronic Data Systems
EPSDT	Early Periodic Screening, Diagnosis and Treatment
FP	Family Planning
GAL	Galactosemia
HCFA	Health Care Financing Administration
HGB	Hemoglobinopathy
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HSR	Health Systems Research, Inc.
HSHV	Healthy Start Home Visiting
IFSP	Individualized Family Service Plan
IQ	intelligence quotient
IMR	Infant Mortality Rate
LHD	local health department
KCI	Kansas Certificate of Immunization
KDHE	Kansas Department of Health and Environment
KSBE	Kansas State Board of Education
LBW	Low Birth Weight
M&I	Maternal & Infant
N/A	Not Applicable
NCCAN	National Center for Child Abuse and Neglect
PedNSS	Pediatric Nutrition Surveillance System
PHS	Public Health Service
PKU	Phenylketonuria
PNSS	Pregnancy Nutrition Surveillance System
PNSP	Pregnancy Nutrition Surveillance Program
SCBW	HIV Seroprevalence Study of Childbearing Women
SIDS	Sudden Infant Death Syndrome
SRS	Kansas Department of Social and Rehabilitation Services
STD	Sexually Transmitted Disease
SSDI	State Systems Development Initiative
USPHS	United States Public Health Service
VLBW	Very Low Birth Weight
WIC	Special Supplemental Nutrition Program for Women, Infants and Children
YRBS	Youth Risk Behavior Survey

APPENDIX D

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APPENDIX E

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